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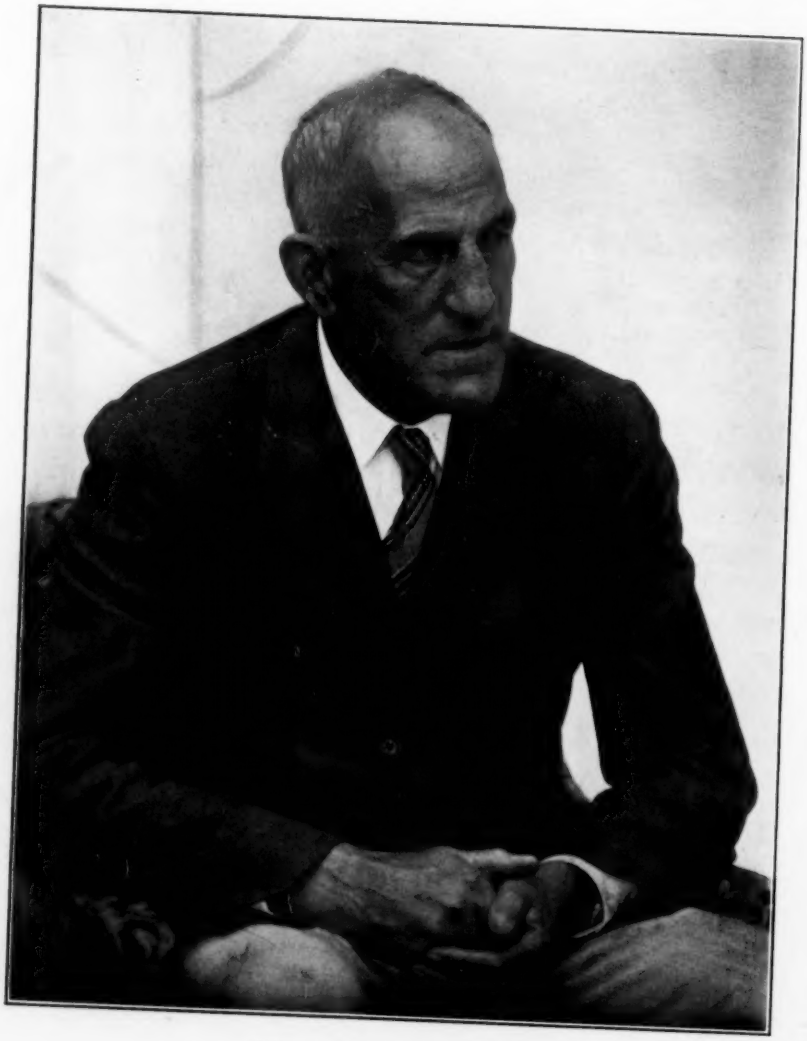

CHARLES SHERMAN LITTLE
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SOME NEW ASPECTS OF THE PSYCHIATRIC APPROACH TO CRIME*

CHARLES B. THOMPSON, M.D.

Department of Hospitals, Psychiatric Clinic, Court of General Sessions, New York City

MUCH time and thought have been given to the control of crime, and to increasing the efficiency of the agencies for the apprehension, punishment, and reclamation of criminals. Witness the development of probation, parole, and the newer principles that are being applied in reformatory management. Witness also the extraordinary development of the United States Department of Justice, and the growing interest in the subject indicated by the increasing number of conferences on crime.

As we know, psychiatry also is being applied to this general problem of crime, and the psychiatric approach includes a number of different aspects. Certain psychiatrists have concentrated upon the problem of the rehabilitation of the prisoner, but while the importance and value of this work are self-evident, it is not with this field that I intend to deal here. This paper represents an inquiry into the causations of crime, and it is my purpose to compare the results of certain studies carried out in the Psychiatric Clinic of the Court of General Sessions, New York City, with the results of similar studies that have been made elsewhere, and finally to formulate the conclusions to which my investigations have led me.

* Presented in briefer form before the Twenty-eighth Annual Conference of the New York State Probation Officers, Buffalo, October 22, 1935.

The Psychiatric Clinic of the Court of General Sessions was established in December, 1931, as the result of the far-sighted action of a group which included Judge Cornelius F. Collins, Chairman of the Probation Committee of the Court of General Sessions; Dr. Vernon C. Branham, Deputy Commissioner of the Department of Correction; the Chief Probation Officer of the Court of General Sessions, Mr. Edwin J. Cooley and later Mr. Irving W. Halpern; Dr. Menas S. Gregory, the Director of the Psychiatric Division of the Department of Hospitals; Dr. William Schroeder, Jr., the Commissioner of Hospitals, who was succeeded by Dr. J. G. William Greeff; aided and endorsed by a committee of psychiatrists including Dr. C. Floyd Haviland, Dr. Frankwood E. Williams, Dr. Sanger Brown 2nd, Dr. William L. Russell, Dr. Mortimer W. Raynor, and Dr. Lawson G. Lowrey; as well as the State Crime Commission, Subcommittee on Causes, the American Psychiatric Association, the Academy of Medicine, and the National Probation Association.

The Court of General Sessions of New York City is the largest as well as the oldest criminal court in this country. All the prisoners who come before the nine branches of the court are examined in the psychiatric clinic during the interval between conviction and sentence, about three thousand cases being thus examined annually. The studies made in the clinic are naturally open to the criticism that the prisoners are not examined as often or over so long a time as the prisoners who are seen in the clinic of a correctional institution, in which they may remain for a period of years. On the other hand, our studies have the advantage that the prisoner is seen soon after his arrest, when he is still reminiscent of his familiar haunts and associates and still fresh from his adventures while at liberty, so that the reactions that led to his incarceration are perhaps more clearly in evidence.

The general conception of the part played by psychosis and mental defect in the causation of crime is still colored by the results reported in early psychiatric studies. One of the early studies, for example—that made by Dr. Bernard Glueck at Sing Sing in 1917—aroused great expectations as to the potentialities of psychiatric study because of the pro-

portionately large number of cases of mental incapacity that were disclosed in the series of prisoners examined.[1] The results of the examination of 608 routine admissions to that prison were as follows: mentally diseased or deteriorated, 12 per cent; mentally deficient, 28 per cent; psychopathic personality or constitutionally inferior, 19 per cent. Here we see that the concepts of mental disease, mental deficiency, and psychopathic personality, taken together, are employed to cover 59 per cent of the prison population. Subsequent observers of the same period reported practically the same percentages. For example, Dr. Frank L. Christian, studying at Elmira, reported 58 per cent; Dr. V. V. Anderson, working at Clinton, 60 per cent; and Dr. Frank L. Haecox, in his studies at Auburn Prison, reported 61.7 per cent.

It must be remembered that Glueck's study was a pioneer effort and that it, therefore, deserves all the credit it has received. More recent studies, however, would indicate that his figures are somewhat high. The results of our study show considerably lower percentages for the three categories in question. To take, for example, those diagnosed as psychotic, of all the prisoners so far examined in this clinic, the psychotic patients made up about 1.5 per cent. The incidence would be a little higher if all slightly deteriorated individuals were included, and all who were recognized before trial and committed to institutions before they reached the court, but it would still by no means approach the figure quoted by Glueck.

Incidence of Psychosis.—In Table 1 we present the incidence of psychosis among all the prisoners who have reached the Court of General Sessions. In the event that a prisoner shows evidence of psychosis prior to trial, he is sometimes sent directly to Bellevue Hospital, or he may be examined by a commission appointed by the court without being referred to the clinic. In order to obtain the total number of all psychotic prisoners who have passed through the Court of General Sessions, we have added to those who were examined in the clinic the number examined by commissions directly without being referred to the clinic, and those who were declared insane by Bellevue Hospital and commit-

[1] See *First Annual Report of the Psychiatric Clinic in Collaboration with Sing Sing Prison, for the Nine Months Ending April 30, 1917.* New York: The National Committee for Mental Hygiene, 1917.

ted to a state hospital without being referred to the clinic or to a commission. Our final figure, therefore, includes all known psychotic cases among the prisoners of this court. For the first three years and nine months of the clinic's existence—namely, up to October 1, 1935—the psychotic cases made up, as we have said, 1.5 per cent of all the individuals who were convicted or who pleaded guilty in this court.

Incidence of Mental Defect.—Our data with regard to mental defect were obtained as follows:

Each prisoner who comes to the clinic is examined by a psychiatrist, and in the course of the psychiatric interview,

TABLE 1.—INCIDENCE OF PSYCHOSIS AMONG PRISONERS OF THE COURT OF GENERAL SESSIONS, NEW YORK CITY, 1932–1935

		Prisoners found psychotic				
Year	*Number of prisoners examined*	Total	Per cent of number examined	Seen in clinic	Seen by commission	Seen by Bellevue Hospital
1932.....	1,910	45	2.3	16	25	4
1933.....	2,475	41	1.6	15	21	5
1934.....	2,983	28	0.9	14	14	0
1935 *	1,888	22	1.2	12	8	2
Total	9,256	136	1.5	57	68	11

* First nine months.

an approximate estimate is made of the subject's intelligence level. These approximate estimates have been found to accord very closely with the final results of the psychological examination. Every prisoner who, during the psychiatric examination, gives any indication of being dull, either by his responses, his slow reactions, or his manner, or because of any suggestive events in his history, is referred for a psychological examination, so that all cases likely to show defect are sifted out and given psychological tests. No case is diagnosed as mentally defective except after having been tested by two or three psychological tests. In the examination of the prisoners referred to in this paper, we used a mental age of 10–6 and an I.Q. of 70 on the fifteen-year level as the upper limit of the defective group. All prisoners who received this rating or a lower one, as well as presenting other characteristic reactions, were listed as defective. Added

to those found defective in our clinic are the mental defectives who were examined by a commission or at Bellevue Hospital and committed immediately without having been referred to the clinic.

It must be remembered, therefore, that our figures are the results of the examinations of all prisoners who are convicted or who take a plea before this court. They cannot be compared with the results of clinics in which only those prisoners are examined who attract attention by some conspicuous feature of behavior or history. Comparable reports of routine examinations of prisoners are to be found in Massachusetts, where all prisoners of a certain category[1] receive a psychiatric examination before trial, but here again there is a difference in that many prisoners are thus examined who are later dismissed by the court as not guilty.

The mental defectives examined and noted in this clinic during its first three years and nine months made up only 2.4 per cent of the total number examined. This is due in part to the marked change in criteria that has taken place since the time of Glueck's studies. For example, Glueck pronounced a prisoner defective who had a mental age of below twelve years. At the time at which he wrote, all individuals with a mental age of less than 12 were generally considered to be defective, and many of those in the upper groups were committed to institutions for the feebleminded. If we take the less rigid classification in use in our clinic, ruling out those with a mental age between 11 and 12, approximately 58 per cent of those listed in Glueck's study as defective would be eliminated, and the final result would be that the defectives comprise about 7.3 per cent of his total number. This corresponds very closely with the figures taken during the organization of the U. S. Army in 1917, when 94,000 men were examined, representing a fair sampling of the civil population.[2] In this army survey, the defectives were found to be 7.1 per cent of the total. Murchison, in his

[1] This includes all those who have been indicted for a capital offense or who have had a previous felony conviction or two or more previous indictments.

[2] I refer to the work of Yerkes, Bingham, Goddard, Haynes, Terman, Whipple, and Wells. According to the results of the very extensive use that was made of their tests in the army, 7.1 per cent of the draft group were found to be "very inferior," which term is commonly taken as the equivalent of the term "mentally defective" as used in other psychological tests.

studies, in which the Alpha test was employed, comes to the conclusion that the criminal group are superior to the white draft group.[1]

The results of the studies made in this clinic are presented in Table 2.

In Massachusetts, where all of the more serious offenders are examined prior to trial as a matter of routine, the report of Dr. Winfred Overholser, Commissioner of the Massachusetts Department of Mental Disease, for 1931 to 1934 inclusive, shows that an average of 14.1 per cent presented mental

TABLE 2.—INCIDENCE OF MENTAL DEFECT AMONG PRISONERS OF THE COURT OF GENERAL SESSIONS, NEW YORK CITY, 1931–1935

		Prisoners found defective					*Prisoners examined by psychologist*	
Year	*Number of prisoners examined*	Total	Per cent of number examined	Seen in clinic	Seen by commission	Seen in Bellevue Hospital	Number	Per cent found defective
1932.....	1,910	49	2.6	47	0	2	1,122	4.2
1933.....	2,475	61	2.5	59	0	2	511	11.5
1934.....	2,983	69	2.3	66	3	0	556	11.9
1935 *	1,888	45	2.4	42	2	1	455	9.2
Total	9,256	224	2.4	214	5	5	2,644	8.1

* First nine months.

disease or defect.[2] Only 1.7 per cent of the total, however, were found to have such a degree of mental disease or defect as to be considered legally irresponsible. This compares with our figure of 3.9 per cent as representing the total of both psychotic and mentally defective prisoners.

In a paper presented before the National Conference of Social Work in Montreal, June, 1935, Dr. Walter Bromberg,[3] of this clinic, pointed out that of the 4,385 cases studied in the first two years of the clinic's activity, only 2.2 per cent

[1] *Criminal Intelligence*, by Carl Murchison. Worcester, Mass.: Clark University, 1926. p. 157.

[2] See "The Briggs Law of Massachusetts: A Review and an Appraisal," by Winfred Overholser, M.D. *Journal of Criminal Law and Criminology*, Vol. 25, pp. 859–83, March-April, 1935.

[3] See "A Psychiatric Study of the Adolescent Offender," by Walter Bromberg, M.D., in the *Year Book* of the National Probation Association, New York, 1935.

were actually mentally defective. This percentage varied slightly among the various groups of offenders, including the adolescent and adult first offenders and repeaters, the highest being in the group of adult repeaters, of whom the defectives comprised 2.6 per cent. As Dr. Bromberg pointed out, when the percentage of defectives among criminals is no greater than among the civil population, it is evident that mental defect cannot be given a prominent place as a factor causative of crime.

Individuals with the keenest minds can and do engage in antisocial activities as readily as those who are duller, and their very astuteness makes it impossible to estimate their full number because it is so much more difficult to bring about their apprehension. When it comes to the realm of actual behavior, shorn of all the circumstances that denote differences of economic and cultural levels, I do not find any essential difference in the mechanism by which the intelligent man takes up crime—crimes of acquisition, for example—and that followed by the person of "inferior" intelligence. In either case, the individual feels that he wants something which it is difficult or impossible for him to obtain through legal means; he is willing to gamble his freedom for it and does so. If he gains what he desires, he tries again and again until he loses, or, as we say in legal terms, is apprehended. The common urge to gamble, for example, as we see it manifested at the race track, on the stock exchange, or even in the homely poker game, varies but little in character with the degree of intelligence.

It appears, then, from the foregoing tables, that only a very small percentage of criminals are psychotic or mentally defective individuals. Even if the percentages were several points greater, the total for both classes would still be relatively small.

The concept of psychopathic personality has remained in use even to the present time and is employed by the psychiatrists in various clinics to account for a large percentage of crime committed by the individuals whom they examine. The term, psychopathic personality, while covering widely varying types of reaction, refers in general to those individuals who are emotionally very unstable, so much so that they are unable to adapt to any settled routine of application,

with the result that they are to a very marked degree undependable. The group includes those who, without being outspokenly psychotic, are cyclothymic, schizoid, or paranoid in their reactions, and who are apparently insusceptible to any known methods of treatment. In every psychiatric clinic, individuals who evidence psychopathic personality are found in considerable numbers. In some clinics, especially those that are connected either with courts or with penal institutions, it has not infrequently been the practice to diagnose an individual as psychopathic merely on the basis of his antisocial behavior, with no regard to his background. To take an extreme case, this would mean that an individual who had been trained up from infancy in a life of law-breaking was necessarily psychopathic because he continued to follow this way of life as a means of livelihood. We do not believe this to be the case.

A somewhat extensive classification of personality types has been utilized in the studies conducted by this clinic. This was presented in its original form in May, 1934, before the American Psychiatric Association by Dr. Menas S. Gregory,[1] who was at that time Director of the Psychiatric Division of the Department of Hospitals, of which this clinic is an integral part. During the period when this classification was used in its original form, the diagnosis of psychopathic personality was applied to a relatively large number of individuals, at times merely on the basis of antisocial behavior. We have revised this classification to some extent, but we have altered still more extensively our application of it. Many individuals who are examined in this clinic we now regard as normal or average individuals with an exaggeration of some particular personality characteristic, rather than as psychopathic personalities or deviates. The classification that we employ at present is as follows:

A. *Psychosis*

The diagnosis of the psychotic cases follows the standard revised classification of the American Psychiatric Association.

B. *Border-line psychosis*

Includes emotional instability with organic defects such as cerebral arteriosclerosis, lues, post-encephalitis lethargica, and the transitory psychoses.

[1] "Psychiatry and the Problems of Delinquency," by Menas S. Gregory, M.D. *American Journal of Psychiatry*, Vol. 91, pp. 773–81, January, 1935.

C. *Mental deficiency*

1. High-grade moron
2. Middle-grade moron.
3. Low-grade moron.
4. Imbecile. (Very few imbeciles have been referred to this clinic.)

D. *Psychopathic personalities*

5. Schizoid type.
6. Paranoid type.
7. Cyclothymic type (chronic hypomanic types, and so forth).
8. Sexual type (overt homosexuals and perverts; often also those who commit sexual crimes).
9. With constitutional inferiority (outstanding structural defects with accompanying general inferiority of mental and moral fiber).
10. With drug addiction (deteriorated socially and ethically).
11. With explosive aggressive tendencies (epileptoid).
12. Chronic (and periodic) alcoholic types with ethical and moral deterioration; may progress to outspoken psychotic deterioration.

E. *Neurosis*

13. Cases of definite clinical neurosis are included here. May or may not have reference to offense. Also includes cases with underlying anxiety, obsessions, hypochondriasis, phobias and compulsions, and inferiority reactions in which there is compensation for feelings of inferiority.

F. *Normal individuals with predominant personality characteristics*

14. Aggressive type.
    a. Antisocial and inconsiderate; primarily aggressive in behavior (as shown by offense or otherwise); also those adjusted to criminal life, as gunmen, and so forth.
    b. Aggression released by alcohol.
    c. Aggression in reaction to inferiority.
15. Unstable type—impulsive; not cyclothymic, but impatient, restless, and impetuous, quick to react to any stimulus; usually a younger person.
16. Swindler (hysterical) type—pathologic lying; expansive, sanctimonious, self-deceptive.
17. Unethical, sly, wily type; professional gambler or "con man"; professional criminal of the planning, careful type.
18. Shrewd type; business man on the border of illegitimacy, or who has indulged in occasional illegitimate behavior in the course of his business career.
19. Adolescent type.
    a. Adolescent immature type with or without schizoid features; phantasying, perhaps with masturbation complex or sex difficulties; imaginative, but with enough integration to keep from going into a psychosis later on; "vague" individuals, immature for their age.

b. Adolescent adventurous type; temporarily antisocial; immature social understanding and emotional immaturity that will develop to maturity later in life; largely the result of the conflict between the desire for adventure inherent in youth and the restriction of such opportunity caused by city environment.

20. Adult immature type; the individuals who remain adolescent, unstable, thoughtless, and excitable, although of adult years.

21. Egocentric and selfish type; basically narcissistic in an openly expressed way.

22. Shiftless, lazy, uninhibited, pleasure-loving type; hedonistic; have energy, but prefer to use it for pleasure rather than settling into regular employment; uninhibited in the sense of keeping pleasure uppermost; usually young individuals. May mature later in life. Influence of gang ideology important.

23. Suggestible type; readily dominated by aggressive companions; usually found only as accomplices.

24. Adynamic, dull type; anergic; lack of drive, especially industrially; narrow, inadequate type; poor economic level. Differ from the dull and stolid persons, as the latter can be adjusted.

25. Nomadic type; men who have developed no true home ties; no social or family attachments throughout their lives, and who have schizoid tendencies, but are not definitely schizoid. Includes the frank vagrant as distinguished from itinerant workers who travel through necessity, as fruit pickers, harvest workers, and so forth.

26. Primitive type; usually rural Negroes unused to complex life of the city; not of inferior intelligence; behavior is largely instinctive and the reactions appear in simple patterns.

27. Adjusted to low economic level (poor environment and activity); nondescript type; usually lower level of economic adjustment; may have deep (unconscious) neurotic reaction against mediocre life; often one offense per lifetime, usually after middle life.

28. Personality adjusted to ordinary, average life; offense usually "accidental," committed through unusual necessity and not apt to recur.

This classification,[1] besides having a certain value as a practical means of grouping prisoners according to type, assists us also in making some form of prognostication as to the probable trend of the individual's development—especially with regard to the question whether the tendency is in the direction of antisocial behavior or of social adjustment.

[1] Since the various types of individual referred to under the captions of the classification were described at length in Dr. Bromberg's article, already referred to, I shall not discuss them here.

It may be of some administrative value also if it increases our facility in dealing with the various types of prisoner by contributing to our understanding of them.

The classification, however, is open to certain very justifiable criticisms. The same individual may fit equally well into several of the various types described, because they merge and overlap. In addition to this, the individual is classified merely by his general reaction type and this may shift from one type to another over a period of weeks or months. But most important of all is the fact that there are many persons in civil life who could be fitted into a number of these general reaction types, but who nevertheless do not follow an antisocial career. We know many aggressive individuals who would never consider committing a hold-up and many lazy individuals who never turn to illegal activities, although they may suffer serious financial difficulties.

In the classification that we employ in this clinic, the term psychopathic personality is applied only to those individuals who consistently show the reactions characteristic of this reaction type. We do not assume, because an individual leads an antisocial life, that he is necessarily of psychopathic personality. This is a point that I wish especially to emphasize. Psychopathic personality is one thing, and antisocial attitude is another. We may find a psychopath who is antisoial, but an antisocial attitude does not necessarily designate the individual as belonging to the group referred to as psychopaths.

By an antisocial attitude we mean an attitude which justifies as a complete plan of life such aggressive acts as are harmful to others and put severe restrictions upon their rights and liberties. It does not necessarily mean that the individual is emotionally unstable or that he has, for example, schizoid or paranoid traits. Very often an antisocial individual cannot be distinguished by his appearance and ordinary behavior from those who occupy places in the average, workday world. The conventional psychiatric concept, psychopathic personality, often employed because the individual is antisocial, affords no clue as to how the individual may have developed his reaction or to what extent it might be altered by appropriate treatment.

It is true that the antisocial individual who appears in the

clinic often shows a typical antisocial reaction dating from childhood. He may feel that he has been subjected to abuse and injustice and that he is necessarily in conflict with those whom he considers to be in authority. It is usually found, however, that this reaction has been associated with disadvantageous experiences of a closely personal character which began at an early age, although these factors may sometimes be difficult to detect. As one possibility, the individual may have been a misfit in school, constantly given classwork that he could not encompass no matter how hard he tried, with the result that he felt constantly frustrated and inevitably became resentful toward all in authority. Or, through the loss of one or both parents or their separation, he may have been placed in the custody of other people or of an institution and been impressed with the indifference and lack of understanding of those who had control over him. On the other hand, he may have been overindulged from infancy, so that he was trained to expect that he would always be taken care of, and that whatever he chose to do would be excused. This eliminates all resourcefulness and enterprise and gives an unreal character to his social relationships.

A background of social position and economic ease does not by any means eliminate any of these possibilities. Even in the course of the ordinary, average life in comfortable circumstances, a child may have been exposed to a sadistic attitude or to overindulgence or some other neurotic reaction on the part of his parents, his teachers, or his companions.

On the stricter basis of classification that we now employ in this clinic, the number of prisoners diagnosed as psychopathic personalities has dropped from an average of 25 per cent of the total number of prisoners seen in one year to 5 per cent of the total.

As we find that psychosis, mental defect, and psychopathic personality account for only a small percentage of the crimes committed, it is evident that most of our field—namely, that which has to do with the factors that lead individuals to commit crimes—requires further investigation. A study that we are now making of repeaters—who constitute about 60 per cent of our prisoners—throws some light on the individuals who have an antisocial adaptation.

We find first of all that the offenses committed by a re-

peater follow a rather consistent pattern. Each individual seems to keep to one type of crime and usually repeats it in much the same way. A burglar, for example, usually commits only burglaries; he very rarely takes up any other form of crime. And each burglary is committed after his own often very characteristic fashion. If there is any alteration in the nature of the crime, it is through a progression of closely allied crimes.

As a second fact of interest, one finds among these repeaters a wide range of ability and a wide variation in reaction types. There are bold and aggressive criminals and there are furtive, dull, and bungling criminals. As a rule, the bold and reckless individuals turn their hands to the more aggressive crimes, such as robberies ("hold-ups"), while the less bold follow the less dangerous offenses, such as picking pockets or small burglaries. The more resourceful may include the brilliant swindlers who have dealt in millions. The dull defective may have merely broken store windows.

As a further circumstance, the repeaters evidence that their behavior has a certain automatic or reflex quality and that they are unable to alter their antisocial actions. One not infrequently sees individuals who have had a repetition of arrests for a series of the same offenses, with gradually increasing sentences, so that the penalty which finally threatens them in the event of the crime amounts to a considerable period of years.

For example, let us take a young man who has been "on the road" since the age of thirteen or fourteen and who has committed a number of aggressive crimes for which he has spent most of the past few years in jail. Finally, he is again placed upon parole. He knows that an offense means incarceration for ten years or more; but two months later he is apprehended as he tries to hold up a barroom.

Or take the young burglar who has repeatedly "done time," and who has reached the point where another offense will involve him in a serious sentence. He passes a tenement house one morning while destitute and begins to think of the possibility of taking something. He enters and finds an apartment door unlocked, and shortly after is apprehended for burglary. This is merely an example of the irresistible

nature of the special setting and stimulus to which the individual is conditioned.

The repeaters tell us that the experience of acquiring money without effort by a bold, swift action is usually enough automatically to paralyze all interest in the quiet, routine pursuits of average life. Antisocial individuals have for the most part undergone this experience so early in their careers that they do not acquire a skilled trade, and hence have no legitimate means of earning money except in meager amounts.

Prison life, moreover, has a deadening effect on the capacities of many individuals, reducing their interest and resourcefulness. People are developed by the demands of their environment, and if these demands are cut off, their enterprise and capacity diminish, so that when prisoners are discharged from prison, they lack the initiative necessary to establish themselves in legal activities, and this adds to the ease of return to their habitual antisocial reaction.

When we come to study the attitude of the repeater criminal, we find that repeaters as a class are not self-critical. They feel quite justified in their illegal activities, which seem as natural to them as our habitual activities do to us. They think and speak of their antisocial activity as their "work."

From consideration of innumerable data such as the foregoing, it is gradually becoming evident that if we are to understand the causations of crime, we must discard the conventional psychiatric approach which studies patients or prisoners as individuals who present symptoms and who are somehow of a different fiber from ourselves. There is indicated the need for an entirely new approach which will include all of us who constitute society and not merely those individuals who become involved with the law.

We can recognize that normal individuals are sometimes caught in a combination of circumstances that forces them to commit a crime in the interest of self-preservation, such as stealing food when one is starving. This seems justifiable and natural to us. But further than this, when without bias we enter inclusively into all the circumstances of most of the repeaters' crimes, they seem as understandable as those of the average man with whose difficulties we sympathize and with whom we can identify ourselves more readily.

That I may not be considered too radical in taking this position, let me point out that there is no permanent defini-

tion as to what constitutes crime, even the so-called "basic crimes." An individual may or may not be denoted as a criminal according to whether sufficient evidence is available, or whether the jury is favorably or unfavorably disposed toward him, so that we see this form of classification is quite undependable. There is no essential difference between the man who extorts a few dollars from a small merchant on the threat of taking away his business—his livelihood—and the employer who arbitrarily terrorizes his employees with threats of dismissal or the cessation of their livelihood. We can readily recall that the transportation or sale of liquor was denoted as crime a few years ago, but is now duly licensed as legitimate business. There is no consistency in our regarding it as heroism for a man to kill others merely because two nations engage in war, when we punish this same action as a crime in civil life. Crime comprises a certain arbitrary category of actions, while many similar actions bearing the same characteristics may, under different circumstances, have the approval of society and not be considered as crime.

Apart from those infractions of the law which are forced upon the individual by some necessity, such as the need for self-preservation, there exists beneath all crime what is commonly known as aggressiveness and indifference to others. Aggressiveness in the individual cannot be separated from aggressiveness on the part of a nation, such as is manifest, for example, when one nation invades the territory of another and proceeds to kill off its members. To understand these phenomena we must study the competitiveness and aggressiveness that are included in the make-up of all of us. "Competition is the life of trade," and also of most of our sports and diversions. However much one may point to the necessity of competing with others in a competitive world, when one views this broadly, there must be something in the state of mind of all individuals that they, as a whole, tend to compete with one another instead of to coöperate, as was necessary for existence in primitive times. There is, furthermore, a certain obsessive pathological quality about this incessant competition, since it interferes with measures that are for the general good, such as public health, and since it leads to industrial unrest and international war. This mode of reaction involves on the part of each individual a pre-

occupation with his own interests, and if we observe our reactions hour by hour and day by day, we can note that we are most of the time inevitably concerned with problems of our own advantage or disadvantage. When we find that the law-breaker follows what he considers to be his own particular self-advantage, it does not seem so utterly foreign to reactions which we all commonly experience, although we may have very different ideas as to what constitutes the greatest advantage. A comprehensive study of this problem includes, therefore, all those factors in man's make-up which enter into his feeling and thought processes to cause the reaction we designate as competition.

Other factors, too, become more understandable when regarded from an inclusive point of view. Though that individual may seem quite sinister who continually reacts in an antisocial pattern, the more central factor or situation is expressed in the statement that he is following his habitual mode of behavior; he is doing merely what he is accustomed to doing. Habit, as we all know, plays a very considerable part in the lives of all of us.

It is by no peculiarity of make-up that the person who has once acquired a large amount of money by a bold, quick action loses interest in the monotony of everyday routine occupations. It is almost universal among those born to riches, for example, that they shun the prosaic task; likewise do those who make a "lucky strike" at the race track or in the casino. Among ourselves, too, it is almost the rule that the recipient of a fortune retires from the exactions of routine work. It is readily understandable, then, that the law-breaker who finds his illegal activities very profitable yields up forever his interest in work, and literally becomes addicted to antisocial pursuits.

The scope of this paper does not permit that we do more than indicate the need for a new and inclusive approach. In this connection, I wish to call attention to the researches of Dr. Trigant Burrow, Scientific Director of The Lifwynn Foundation. These investigations into the nature of human behavior, which have been in progress now for over a decade, have proceeded from a broad generic basis that includes the entire race of man as the subject of study. Emphasis is not so much upon the superficial symptomatic manifestations we are accustomed to look at in the behavior of the other fellow

as upon the motivations that underlie the behavior of all of us as a species. Accordingly, the discrepancies and vagaries of our so-called normal or average life are included as a matter of course within the scope of this broader objective approach to man's behavior. Of more recent years, Burrow has concentrated his study upon the biological and physiological processes that underlie what we are wont to consider as behavior disorders, and these he has described in his more medical writings. Of especial interest for this paper, however, is an article of his entitled "Crime and The Social Reaction of Right and Wrong," which appeared several years ago in the *Journal of Criminal Law and Criminology*.[1] This article embodies the broad societal approach to which I have referred and discusses the undependability of the feeling of "rightness" and its relation to the reactions called crime.

CONCLUSIONS

The diagnoses of mental defect and psychosis do not occur with sufficient frequency to appear as a considerable cause of crime. Another familiar diagnosis, psychopathic personality, when determined on grounds exclusive of antisocial behavior, does not occur in a large proportion of cases. The repeater criminals who do not belong in any of the above three categories we find have an antisocial attitude or adaptation; that is, they grow up to antisocial lives just as the ordinary citizen does to a regular occupation, and their acts have a certain automatic quality beyond the control of the individual. These reactions are not accessible by the conventional psychiatric approach, but it is my conclusion that if all the circumstances in each case could be included comprehensively, accurately, and without bias, the reactions of antisocial individuals would for the most part appear as understandable to us as those of the average "steady-going" citizen.

Psychiatrists are constantly seeking to discover more about the individuals whom they are studying and the influences that bear upon them to fashion their behavior. The purpose of this paper is to indicate the necessity for a new and broader method in the study of crime, which would regard crime as merely one expression of the factors that underlie human behavior.

[1] Vol. 24, pp. 685–99, November-December, 1933.

EMIGRATION AND MENTAL HEALTH

ÖRNULV ÖDEGAARD, M.D.

Department of Public Health of Norway and Psychiatric Clinic of the University of Oslo

DR. BENJAMIN MALZBERG'S interesting study of mental disease in New York State according to nativity and parentage [1] gives me the opportunity of calling attention to a similar study of my own.[2] My findings were practically the same as those of Malzberg, but the conclusions differed somewhat, which may make a comparison useful.

The material of this study differed from Malzberg's in some important respects:

1. Among the heterogeneous masses of the foreign born, one group, racially, socially, and culturally fairly well defined, was selected—the Norwegian born of Minnesota.

2. The rate of first admissions among the Norwegian born of Minnesota was compared not only with the native born of the same state, but also with that of the population of Norway. This made it possible to attack the problem from more angles, and also to exclude many sources of error.

3. Diagnosis in psychiatry is still so much a matter of personal opinion that it seemed inadvisable to make statistical comparisons where the diagnoses were made by different psychiatrists, in different hospitals, or even in different countries. Therefore, representative samples were selected (about 1,100 cases from the state hospital at Rochester, Minnesota, and about 2,000 from the Gaustad state hospital in Norway) and the diagnoses were made by the author himself, in each case after careful reading of the case history. This selected material proved very useful even for the study of factors like occupation, residence, and marital condition, which are not shown in the tables of the official statistics.

The main findings are presented in the tables that follow.

[1] MENTAL HYGIENE, Vol. 19, pp. 635–60, October, 1935.

[2] *Emigration and Insanity; A Study of Mental Disease Among the Norwegian-born Population of Minnesota.* (*Acta Psychiatrica et Neurologica*, supplementum 4.) Copenhagen: Levin and Munksgård, 1932.

TABLE 1.—RATES OF FIRST ADMISSIONS TO INSANE HOSPITALS, ALL DIAGNOSES, CLASSIFIED BY NATIVITY

Material of present study			*Malzberg's New York material*	
	1909–19	1919–29		1929–31
Norwegian born of Minnesota	100	100	Foreign born	100
Native born of Minnesota	78	75	All native born	84
Norwegians of Norway	59	58	Native born of native parentage	69

All rates of admission are given in per cents of the rates for the foreign born, to permit of an easy comparison with Malzberg's New York material. All rates are standardized, to exclude the error caused by the differences in age and sex distribution.

Table 1 shows that the Minnesota Norwegians tend in the same direction as Malzberg's New York foreign born: the rate of admissions per 100,000 per year is considerably higher among the immigrants. Attention is drawn to the interesting fact that the rates are still lower for the Norwegians of Norway; these rates are roughly comparable to Malzberg's rates for the native born of native parentage. The explanation is very simple: the native born of a state like Minnesota are all of them descendants of immigrants in the second, third, or sometimes fourth generation, and they still live in an environment which has many of the traits typical of newly settled communities.

The high rate of admissions may, it might be argued, be an artifact—it may be that mentally diseased immigrants are

TABLE 2.—RATES OF FIRST ADMISSIONS TO INSANE HOSPITALS, CLASSIFIED BY DIAGNOSIS AND NATIVITY

	Material of present study		*Malzberg's New York material*		
	Norwegian born of Minnesota	Norwegians of Norway	Foreign born	Native born	Native born of native parentage
Schizophrenia	100	50	100	68	51
Manic-depressive psychosis	100	110	100	79	70
General paresis	100	73	100	98	78
Alcoholic psychosis	100	34	100	94	69
Senile psychosis	100	13	100	75	55
Arteriosclerosis			100	81	65

more readily committed to state hospitals, for instance, because they belong on the average to the lower social and occupational classes, or because they are more predominantly urban in residence.

Such an explanation might be true in some states, like New York, but it is unlikely that it would play any important rôle in Minnesota. The Norwegians born in this state are predominantly rural, and their social status does not differ much from that of the native born or that of the population of Norway. Of course comparatively few immigrants are able to enter the well-to-do business and professional classes, but the percentage of the population that belongs to these classes is so small even among the natives that their hypothetically low rate of admissions cannot possibly influence the statistics to any great extent. Moreover, private sanitariums for the upper-class insane are scarce in Minnesota, and in Norway such institutions are included in the official statistics. According to the author's experience as a physician in mental institutions in both countries, the chances that an insane person will be committed is practically the same in both.

The conclusion must be that the difference in rates of admission is much too marked to be explained in this way. The fact then remains that there is really a higher incidence of mental diseases among the immigrants. There are two possible explanations for this fact:

1. The mental and physical hardships of emigration and of immigrant life may cause mental derangement in persons who would otherwise have remained sound.

2. The emigrants may comprise a higher percentage of psychopathic or early psychotic types than the rest of the population of Norway. This might, for instance, have some connection with the tendency toward restlessness and social maladjustment which is characteristic of such personalities.

It is evident that these two possible factors are both at work. The problem is merely to determine their relative importance—the well-known psychiatric problem of constitution versus environment.

Among the diagnostic groups, only two contain a sufficiently large number of cases to be of statistical importance: the schizophrenics and the senile and arteriosclerotic cases.

These two clinical groups differ so fundamentally with regard to pathogenesis that the problem of constitution versus environment must be discussed separately for each of them.

The senile and arteriosclerotic disorders are more than seven times as frequent among the Norwegian born in Minnesota as in Norway. From what is known of the etiology of these conditions, it seems improbable that constitutional factors should be responsible for this tremendous difference. A detailed study of the present material confirms this: the incidence of psychopathic heredity as well as of psychopathic traits in the pre-psychotic personality is substantially less among the Minnesotans.

Factors of a social nature are probably more important. In Norway there may be a greater tendency to keep such patients at home instead of having them committed. The unsettled social conditions of the immigrant community, as well as the comparatively poorly developed system of old people's homes, makes this more difficult in Minnesota. A study of the duration of the disease previous to admission, however, seems to indicate that this social factor may not be as important as might have been expected. These patients are actually admitted at an earlier date in Norway than in Minnesota, which would hardly have been the case if the tendency to avoid commitment had been much stronger in Norway.

The most likely explanation is that the high incidence of the psychoses of advanced age among the Norwegian born of Minnesota is due to the mental and physical strain of immigrant life. The labor is more strenuous than in Norway, with longer hours and more rush. The change toward a diet more rich in meat, eggs, and pork, at the expense of cereals, milk, and fish, may even play some rôle. And last, but not least, the mental strain upon people in the forties and fifties is much worse in America, owing to the highly developed industrialization and the inefficiency of the systems of pension and social protection. It is quite natural that all these difficulties should be felt particularly heavily by the immigrants, who have had a comparatively late start in life.

An important statistical point in favor of the environmental hypothesis lies in the fact that the age at onset of the psy-

chosis is definitely lower among the Minnesotans than in Norway, as will be seen from the following table:

TABLE 3.—AGE OF ONSET OF SENILE AND ARTERIOSCLEROTIC PSYCHOSES AMONG NORWEGIANS IN MINNESOTA AND IN NORWAY

Age of onset	*In Minnesota*	*In Norway*
40–44	1.86	0.93
45–49	4.29	0.93
50–54	19.37	12.04
55–59	21.11	10.18
60–69	38.52	53.70
70 and over	14.85	22.22
Total	100.00	100.00

Schizophrenia is about twice as frequent among the Norwegian born of Minnesota as in Norway. (See Table 2.) Malzberg's New York material shows practically the same result when the foreign born are compared with the native born of native parentage. The environmental explanation may be used even for this reaction type: the mental and physical hardships of immigrant life may lead to a schizophrenic deterioration in personalities who may be predisposed, but who in their own home country would have managed to maintain a mental and social balance. A detailed study of the material gives no positive support to this hypothesis, however, and a number of facts seem to point in an opposite direction:

1. The age at onset of the disease is the same in both population groups. If difficulties of adaptation, and so forth, had played any significant part, the psychosis would have tended to start at an earlier age in the immigrant groups than in Norway. (The difference in age distribution has to be corrected in advance, of course.)

2. The schizophrenic reaction does not show any particular tendency to begin during the first five years of the patients' stay in America, as would probably nave been the case if the said difficulties had been important pathogenic factors.

3. Among the "causes" for the mental derangement given by the patients themselves or their relatives, very few are in any way connected with the immigrant situation. Even if such " causes " given by lay people are generally irrelevant, this fact nevertheless seems to indicate that the strain of

immigrant life has not been a particularly important problem in the minds of these patients, at least not consciously.

4. The symptomatology of the disease is remarkably seldom colored by the fact that the patient is an immigrant; the clinical picture of schizophrenia seems to be exactly the same as in Norway.

These facts may not be absolutely conclusive, but nevertheless they mean that the constitutional hypothesis has to be given serious consideration. In this connection it is important to point out that the incidence of manic-depressive insanity is remarkably low among the Minnesotans—even lower than in Norway. In Norway there are about 1.5 schizophrenic admissions to each manic-depressive, but for the Norwegian born of Minnesota the proportion is 3.5 to one.

The etiology of these " endogenic " psychoses is far from clear, but it seems to be an established fact that their clinical picture depends mainly upon the constitutional make-up. Environmental factors very likely play a part in provoking the outbreak of the psychosis, but from then on the course and symptomatology of the disease are determined: if the patient belongs to the leptosomic-schizoid type, he will tend to develop a schizophrenia, and if his make-up is pycnic-syntonic, his psychopathological reaction will be of the manic-depressive type.

Consequently, if we explain the increased incidence of schizophrenia among the immigrants as a result of environmental factors, how shall we be able to account for the fact that the incidence of manic-depressive insanity does not show a similar increase?

The constitutional hypothesis offers a natural solution. The schizoid type of thinking, feeling, and social relationship must furnish a far more likely background for emigration than the syntonic make-up. The social contact of such personalities is poor, and it is consequently comparatively easy for them to break away from home, friends, and familiar surroundings. They have little ability to make a good social adaptation in early youth; this results in conflicts with parents, sweethearts, teachers, and employers, and may lead to unemployment, or at least may render it difficult for them to make a career satisfactory to their own ambition. Their

sensitive minds react strongly to every real or imaginary misfortune, generally with a stubborn and brooding bitterness, mixed with wounded pride. In this way it seems psychologically most likely that many maladjusted schizothymic personalities should choose emigration as the best solution to social defeats and adversities in the old country.

But the tendency in such personalities to emigrate is not exclusively, or even mainly, a result of their difficulties of social adjustment; even their positive and valuable traits carry them in the same direction. Their ambition and courage, their romantic dreams of greatness and adventure, their ability to sacrifice the present for a remote and insecure future, their intolerant idealism and unwillingness to compromise when it comes to personal, political, or religious ideas—these are all of them character traits that have brought America thousands of its best citizens.

Any one who is familiar with the teachings of Kretschmer and his followers will be able to amplify this sketchy picture, and must agree that the schizothymic constitution is the best possible soil for the idea of emigration. The syntonic type, on the other hand, is in this, as in every other respect, the direct opposite.

A closer study of individual cases gives ample support to this hypothesis. Again and again the case history shows how a schizoid personality or an incipient schizophrenic psychosis was the direct or indirect cause for emigration; whereas no such facts have been available for the syntonic personality or the manic-depressive psychoses.[1]

In view of these facts it seems to the present author that a complete understanding of the problems of emigrants and their mental health is impossible without introducing the constitutional hypothesis—not *instead of*, but *as a supplement to* the environmental one. For instance, the importance of economic conditions, of the labor market, and so on, for emigration is so well established that a discussion of this side of the problem may be omitted here, but it should be stressed that among a group of Norwegians of the same economic and social status, those who have a schizothymic or schizoid make-up are more likely to emigrate.

[1] For case histories, see the monograph by the author previously referred to.

As for the mental diseases of immigrants, a similar interaction of constitutional and environmental factors seems to offer the best explanation of their relatively high incidence. The tremendous excess of senile and arteriosclerotic psychoses probably is a result of predominantly environmental factors—the physical and mental strain of immigrant life, which is particularly hard upon the age groups above forty. For schizophrenia and manic-depressive insanity, on the other hand, the specific difficulties of immigration seem to be of less importance than the constitutional make-up of the immigrants themselves. This does not necessarily mean that these diseases are absolutely independent of all environmental factors. More likely the explanation is that the importance of such specific difficulties has been somewhat exaggerated. After all, the social change which a European experiences in America is, comparatively speaking, of a superficial nature; this at least is true of the Norwegians who emigrate to the agricultural Northwest. The social factors that influence human beings so deeply as to affect their mental health are of an international character.

CONTRIBUTIONS OF PSYCHOLOGY TO MENTAL HYGIENE *

GILBERT J. RICH, M.D., PH.D.
Milwaukee County Mental Hygiene Clinic, Milwaukee, Wisconsin

THE field of mental hygiene, dealing as it does with the behavior of human beings and their social relationships, naturally touches upon and draws material from a number of disciplines which are concerned with various aspects of the study of man. These include psychiatry, psychology, sociology, social case-work, biology (in the narrow sense), medicine, psychoanalysis, and anthropology. Each has contributions to make to the general body of knowledge which we call mental hygiene, yet none is exclusively responsible for the development of this field. Indeed, the study of human behavior leads to no such sharp distinctions. Each of these points of view differs in reality so slightly from many of the others that there is necessarily a great deal of overlapping in their work and their results. Yet in spite of this inevitable overlapping, each science has enough individuality to contribute to our final knowledge of human relationships something that the others cannot give.

How, then, does psychology play its part in the tasks of mental hygiene? We need not be bothered here with the question of what psychology is. Cattell, in 1904, gave us the most usable definition at our command when he said that psychology is whatever psychologists are professionally interested in. Even a cursory perusal of our recent periodical literature will show a marked interest in human behavior, in individual differences, in personality, in social reactions, and in mental abnormalities. In all of these fields psychology has applied its methods and has brought forth results.

For many years the progress of psychological investigation and thought felt upon itself the heavy hand of the past, an influence that it has not as yet entirely escaped. As the

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study of mental life, at a relatively late date, attempted to become observational, experimental, and scientific, it was for many years dominated by the philosophical idea of looking for general laws instead of considering individuals and their differences, although there were scattered studies of a differential sort as early as those of Galton. But in the last decade of the nineteenth century a new, more practical, and less philosophical point of view began to emerge. Much of the impetus came from the pioneer work in this country of Cattell and his students, who were followed later in Germany by Wilhelm Stern and his school. Their work at first was simple in type and was concerned primarily with motor abilities, which were easily tested. The outstanding contributions were the demonstrations to the world that scientific methods could be applied to the study of individual differences, and to the psychological fraternity that human variability could be studied as such and need not always be eliminated as something beyond the realm of science.

But early in the present century there appeared a further development whose results have been and still are far-reaching. Binet and Simon brought forth a scale for measuring intelligence. Here was a new point of view, a synthesis in a measure of the opposed generalizing and individualizing tendencies. The concept of an entity called general intelligence made the work applicable to something more akin to life than the laboratory situations of the motor tests, while the interest in the individual still continued. So widespread have been the consequences of the Binet tests that we must consider them more fully. Space does not permit us to examine in detail the remarkable growth of intelligence testing and of the tests themselves. One may merely mention the work of translation and revision performed by Goddard and later by Terman, the invention of a group test by Otis, the tremendous development of group testing by the psychological service of the army and by those who followed in the years after the war, and the elaboration of non-language or performance tests. We are more concerned here with the applications that have been made of test results.

Binet and Goddard were especially interested in the feeble-minded. An intelligence scale was immediately seized upon

as a diagnostic instrument by means of which the feeble-minded in the community could be picked out. The population of institutions for defectives has been and still is growing rapidly. One may doubt if this is due to an increase in the number of defectives. More likely it follows a better recognition of them in society at large. Much of the impetus toward this recognition has come as a result of our having available so convenient a means of measuring mental ability. Persons who were destined to be misfits in school, family, and industry have been removed from the community and placed in an environment adapted to their needs. Such a change naturally affects both the individual who is institutionalized and those about him who are thereby relieved of the burdens caused by the misfits in their midst. We see this clearly in cases in which the removal of a defective child improves the adjustment of his siblings.

The next important field of application was the school. It was here that mental testing had its first great expansion. Not so many years ago, the curriculum and methodology of the schoolroom were sacred things to which every child was expected to conform. The results of mental testing provided the ammunition for making the first crack in the armor of the old-fashioned pedagogue. School men realized that individual differences not only existed, but could be measured. First came the elimination of defectives, then the segregation of backward and border-line children, and only more recently the widespread recognition that individuals do differ and should be treated accordingly. The result has been a thoroughgoing reorganization of the whole structure of school instruction, a reorganization whose effects upon the social adaptation of those now attending school are so widespread that we cannot even attempt to estimate them. Nor can we ignore the influence of psychological methods in educational planning and administration in connection with the remarkable development of educational tests, themselves a direct outgrowth of psychological tests.

Psychological methods of testing have been applied to special abilities and disabilities, as well as to general intelligence. The work of Bronner may be considered a milestone of progress. The significance of such tests may be

well illustrated by the work that has been done in reading. Monroe has developed not only a series of diagnostic tests of reading disability, but also standardized methods of treating those children who cannot read. The influence of the treatment upon the social adjustment of these children is tremendous. Quite frequently the foundation of a poor school adaptation is removed and the patient changed from a rebel against that which was beyond him to a useful member of a society into which he can fit.

Still another type of expansion for mental testing was opened by the applications of psychology to the tasks of the army. Industrial psychology received not its start, but its driving power from an attempt to use in civil life the means of adjusting persons to their work that had been tried in the military situation. It has been shown to and recognized by many industrial managers that the happiness and the efficiency of workers depend upon their adjustment to their work. So we find psychological methods being adopted to find the best worker for each task, to make the conditions of work most suitable for the human organism, and to guide youth in its choice of vocation.

Those who work outside the field of psychology are too often prone to feel that mental testing represents all that this science has to contribute to life. Such a view is, of course, erroneous. The concept and the formulation of standardized tests have been of importance, but they do not represent the limit of psychological achievement. We must, therefore, omit further consideration of the detailed results of mental testing in order to look at other fields of psychological endeavor.

Nearly forty years ago Witmer established at Philadelphia a psychological clinic. In so doing, he gave a start to the field of clinical psychology. The clinician differs from the experimenter and the tester in that he does not place his main reliance upon apparatus, statistical devices, and other methodology, but is concerned rather with obtaining a detailed knowledge of the patient and his problems. This is, of course, also what the psychiatrist does. But clinical psychology interested itself in the mental side of the problems of children at a time when every other discipline was

ignoring just this phase, a time when psychiatry could see no further than classifications of mental disease and custodial care of psychotics. Its major contribution was a point of view in which the personality and abilities of an individual were considered as factors in his health, his welfare, and his social adjustment. Nor was the psychologist absent when, years later, psychiatrists developed similar interests. One need only recall the partnership of Healy and Bronner in their pioneer work in Chicago.

Psychology has been, however, primarily an experimental science. What results have its laboratories brought forth? There has been much criticism of the sterility of the psychological laboratory and of the futility of the type of research undertaken therein. Is this justified? To some extent it is. But the same could be said of the laboratory of physics if one looked only for facts immediately applicable to engineering. There are many psychological experiments whose results seem inapplicable to life outside the laboratory, but there is an increasingly large body of experimental data that has great social import.

We may first consider the achievements of behaviorism. Whatever one may think of Watson's theoretical formulations, the value of his earlier experimental work can hardly be questioned. The very centering of attention upon an objective study of human behavior as such was an achievement of no mean value. Added to this were the elaboration of methods, and the studies of acquisition of motor control, the beginning of language, and early emotional life. The demonstration that emotive responses are subject to conditioning provided a principle that is most useful in understanding our reactions to all types of situation. By applying it, we can often see where and how a person acquired a particular type of response, and more particularly how he learned it from those among whom he lived. In the practice of mental hygiene, conditioning has been used by David Levy and others as a means of changing emotional responses.

In this connection it is also well to remember the contributions of Pavlov and his school. Although we may consider the conditioned reflex as essentially an application to objective behavior of what was already known about the asso-

ciation of mental processes, the facts that the Russian workers brought to light have markedly clarified our knowledge of the mechanisms of behavior and their genesis. Physiological methods have also been used in the study of emotional responses. The investigations of Darrow with the galvanic skin reflex and other bodily determinations point the way for future endeavor.

With the introduction and acceptance of the evolutionary point of view during the nineteenth century, all departments of biological study began to look at their material from a genetic point of view. Psychology was no exception to this rule. The new standpoint meant that the investigators' attention was turned toward children and the growth of their mental life. This was considered to be of interest both for the understanding of children for themselves and for the light that it could throw upon the genesis of adult reactions and attitudes. The work of Stanley Hall and his pupils, despite the crudeness of the questionnaire method, brought to the attention of the scientific world a large group of facts about the mental life and early behavior of children.

More recently, however, the interest in the psychology of children has been revived. With the methodological point of view that was furnished by behaviorism at hand, first-hand experimental observation of behavior from birth on (and even fœtal behavior in animals) has flourished during the past decade. One need only mention the work done by such child-study stations as those at Iowa, Minnesota, Yale, and Teachers College. We know something of how and when various types of reaction are acquired in the early years of life, what factors condition certain responses, when some types of individual difference appear, when and how certain kinds of social response are first manifested, and many other similar facts. These observations quite evidently tell us a great deal about the beginnings of the behavior that an individual later shows in his relations to the social group and enables us better to understand it in its genetic aspects.

When one deals with the later periods in the individual's life, experimental studies of a genetic sort are not possible because the adult human being cannot be used continuously as a laboratory animal. We have already spoken of the

contributions of mental testing to our knowledge of the intellectual, motor, vocational, and educational abilities of people. But we recognize that the intellectual and motor phases represent a relatively small part of human activity. The remaining sectors of an individual's responses are often grouped under the generic term personality. What do we know of this part of behavior? Have the methods which were applicable to intelligence been applied to this field? Can personality be measured? The development of personality measurements has, indeed, been slow, but definite progress is being made. Many methods are being used. Definite attempts have been made to correlate personality with anatomical structure, physiological functions, and body chemistry. More direct study of the mental phases is evident in the biographical methods and case studies. One of the earliest attempts to place the investigation of personal traits upon a basis of measurement was the rating scale, which is essentially a systematization of individual judgment, but which soon proved itself to be far from satisfactory.

In addition to the use of rating scales as means of differentiating between individuals for practical purposes (as in the army personnel service and in commerce and industry), they have been utilized as bases of theoretical investigation. Examples of this are to be found in the work of Moore and of Thurstone, in which constellations of personality traits occurring in certain mental diseases have been delineated by the application of the methods of factor analysis to data obtained by means of rating scales.

Later came the present profusion of tests of personality. Here at least objectivity is aimed at. The test procedure means the careful observation of a person in a sample situation which is taken as indicating his more general reactions. The difficulty is in finding a sample situation which is an adequate representation of conditions outside the laboratory. For some traits the difficulties involved are insurmountable, while for others they are gradually being overcome. Pitfalls are frequent, but progress is being made and our experimental knowledge about personality is increasing.

Nor can we leave the subject of personality study without some mention of the psychology of types. Attempts to divide

human beings into mental types or "temperaments" are as old as pre-scientific psychology. In recent years they have had a new lease on life as a result of the labors of such investigators as Jung (and his followers) and Kretschmer. Yet it is to be noted that the modern impetus in this field comes primarily from psychiatry, rather than from scientific psychology, where it is better recognized that human traits show continuous variation rather than fall into definite classes.

An understanding of the individual alone gives us only the material from which we can build our knowledge of social behavior. We have already seen that in the case of infants and children the genesis and development of social reactions have been observed. In addition, we are now witnessing the growth of a true experimental social psychology. Studies are being made of the behavior of individuals in the group. Some of the work has been done with school children because the schoolroom offers an available and a partially controlled group. One may mention experiments on the effects of competition, types of motivation, rivalry, social pressure, emotional agitation, and the like. The experimental method has been carried even further, to the observation of group activities as such. Here studies have been made of imitative behavior, conversation, group thinking, and judgment, response to the opinions of others, committee work, the effect of criticism, group conflict, attitudes and the factors influencing them, and group competition. Only a beginning has been made in these types of endeavor, but facts are becoming available and the direction has been indicated for future observation.

Where the human being cannot be properly controlled for experimental purposes, there is always the possibility of working with animals. One must, of course, recognize that the comparative method has contributed far less to human psychology than it has to human anatomy, physiology, or pathology, doubtless because the great evolution of the human race as such has been mental rather than physical. In spite of this, we are obtaining from animals information that would not be otherwise available. Examples of this are the work of Köhler, Yerkes, Klüver, and others with primates, or the studies of Stone on sex motivation. There are many others.

We may next ask how these results have been arrived at. Is there a special methodology that has been used in psychological study? Have especial techniques been developed? Do they differ from those which are employed by the other disciplines that we are considering to-day? Essentially, of course, psychology has no bag of tricks, no all-illuminating principle of study peculiar to itself alone. The general methodology is that of science, controlled observation, but applied to its own peculiar problems. Even the introspective method of the classical psychological laboratory, a method that yields few or none of the data in which we are interested, is only observation applied within a limited range.

If a second reference to the development of psychology from a branch of philosophy to the status of a science may be permitted, it is worth while to note that parallel to the change in point of view there has been a distinct shift in procedure. The intuitive method has become less and less evident, though it has not as yet fully disappeared. In place of intuition has come objectivity, and with it observation and experiment. The growth of psychology has been practically concurrent with and dependent upon its ability to take an objective point of view. This was at first limited to a few topics in which psychologists were interested. The older textbooks contained a few facts about sensation and perception and much theory about the rest of the field. To-day the proportions are quite different, and in every chapter observationally determined facts have replaced ideas that were arrived at merely by a process of reasoning (or of rationalization). We must not, however, think that complete objectivity has been reached here any more than it has in other disciplines. The psychologist is after all a human being and his formulations are always determined egomorphically, at least in part. Such recent controversies as that between the behaviorists and the introspectionists illustrate this.

Nevertheless, the objective methodology is a major contribution of psychology to mental hygiene, and to the social sciences in general. Observation and experiment are its watchwords. Of the various disciplines that we mentioned as making important contributions in our field, several have developed out of what might be called the physical group of biological

sciences in contradistinction to the mental group, and they are already quite objective. The others are rapidly becoming observational rather than intuitive, and in so doing are developing their techniques out of those of psychology.

This statement carries the implication that there are special psychological techniques. Such is the case. The study of behavior in all its aspects presents problems not found in the physical sciences and, therefore, needs special methods for their solution. What are these? First and foremost, probably, is the great variability of the material studied. This has been treated in two ways. On the one hand, it has been taken into account and allowed for, so that general laws and principles could be developed, while on the other hand it has been studied for itself and a differential psychology brought to life. Let us consider, first, the methods of ruling out variability. For this the frequently much despised method of statistics is important. Statistical results are not, indeed, facts, if one means facts of immediate observation. But observational facts readily become too numerous to deal with. Then it is that a statistically arrived at result becomes a usable substitute for that which is unwieldy and unusable. Other biological disciplines, such as medicine, public health, and the like, are coming to realize that the statistical methods which they have despised are, despite their liability to juggling and misuse, the best methods yet evolved for dealing with variate material. The correlational procedures, for example, have received their greatest development in psychology, but are now being applied elsewhere.

Another contribution that has been made on the side of technique is the concept of standardization. Psychological experimentation is, in general, a bit of human social behavior—that is, a bit of the very material that is being studied. It was soon recognized that the experimenter as a person modifies and influences the subject of the experiment. The solution of this difficulty has been standardization. It has become increasingly clear that experimental results are always a function of the procedure used, and that only when rigidly standardized methods are used, can comparable results be expected. Thus we find that the instructions used in experiments or the statements made in giving tests are

rigidly controlled. Not only the words used, but often the gestures, intonations, and facial expressions of the experimenter are specified.

We have noted above that the problem of variability has been met in part by such devices as statistical procedure and standardization. But it has also been studied for itself. The most typical instrument evolved for this purpose is the mental test. It makes use of the techniques we have just considered, but in a special application. A mental test may best be thought of as a means of sampling human performance under standardized conditions. From the sample of behavior is inferred the individual's responses under more general conditions. Thus it comes about that the value of a test depends on the adequacy of the sampling for the objective that one has in view. Of making tests there is no end. Nor is it a very difficult task. But making a test that is of value is quite a different affair. Standardization is first necessary. That this exists must be proven, usually by statistical methods. Then a criterion must be set up for the behavior which is to be sampled, always bearing in mind Johnson's admonition that saying that a test measures such and such a trait does not make it so. Next, the adequacy of the test to the criterion must be determined, and finally, the results of performance on the test must be evaluated and calibrated. All this is a laborious procedure, but without it one has only a hollow mockery of science. We have mentioned already how this technique has been applied to other social fields such as education, and we must count it a major psychological contribution.

In this paper it has been necessary more or less to catalogue what psychology is doing and has done. Before concluding, we should ask what it has not done. The answer is that most of its problems are still unsolved. This is so true that it is almost impossible to pick any one field where help is needed more than in another. But a few such may be mentioned. Our knowledge of emotional responses is woefully inadequate. Mental hygiene and particularly several of the disciplines involved in it are concerned with the emotional side of life. They are gradually gathering data that, as they become more objective and less interpretative, will be of value to psychol-

ogy. This will come slowly, as the scientific replaces the clinical spirit. The study of personality, so vital to each of the fields here represented, is only beginning. Much can be contributed to our psychological knowledge by other approaches and other techniques. Experiments on the reactions of individuals in groups and of groups as a whole are in their infancy. Here, too, help is needed. Taken as a whole, the field of human activities is large. It is too large for any one discipline. Various points of view are necessary. Only as each develops in its own special way and contributes its part to our common understanding can satisfactory progress be made.

EFFECTS OF LONG HOSPITALIZATION ON PSYCHOTIC PATIENTS

EUGENE F. BOGEN, M.D.
Psychiatrist, Veterans' Administration Facility, Danville, Illinois.

ALTHOUGH the treatment of the insane has been continuously improved during the past century, especially in its humanitarian aspects, yet the general situation still leaves much to be desired, from the point of view of the interest of the patient as well as that of public economy. The "madhouse" is no longer a place of horror; maniacs and "lunatics" are no longer chained and treated as wild animals, since we know now that these conditions are diseases like any others. Yet both in the medical profession and among the public, the mistaken idea still persists that such unfortunate persons must be kept locked up or isolated from community life for long periods, if not for the term of their natural lives; that they are incapable of adjustment to normal conditions—in other words, incurable.

To be sure, in the past attempts have been made to end the hospitalization of mildly "insane" persons, and largely for economic reasons, deliberate attempts are being made now in some state hospitals in the direction of a rapid discharge of psychotic patients on trial visits. But on the whole, both the profession and the public have yet to be won over to the idea that mental diseases, like organic diseases, can in a very large percentage of cases be either entirely cured or at least sufficiently cured to enable the patient to return to a more or less normal mode of life. Patients treated in general hospitals for physical diseases are discharged very often with a certain degree of disability with which they have to carry on during life. In the case of mental disease, also, the evidence seems to suggest that only a rather limited percentage of patients will need long or permanent hospitalization. In the majority of cases there seems to be no necessity for long hospitalization; rather it appears to be detrimental to the patient. Within reasonable limits, the shorter the term of hospital

life, the better are the chances for a rational readjustment of certain classes of psychotics to community life.

The function of any hospital is to cure disease and to restore the patient as rapidly as possible to economic and social adequacy. The function of a mental hospital is in no way different, yet it seems to be a more or less generally accepted idea that when a patient is "committed" to a mental hospital, he must remain there indefinitely, deprived of his liberty and very often given very little opportunity of regaining it or of again becoming economically independent. He becomes a burden to the state and a helpless, timid, irresponsible being. Yet very often such a patient is only temporarily out of tune with or maladjusted to his community surroundings. Therapy should aim to restore his capacity to adjust, at least approximately. It is *not* the province of the mental hospital to keep him isolated indefinitely and to perform every service for him, so that he entirely loses initiative and interest in helping himself and becomes passively irresponsible and dependent upon others. Probably a large number of patients in general hospitals would become so also if they were treated as mental patients are and allowed to become public charges for all their needs. If the therapy practiced within the mental hospital is such that the patient can be made to adjust there, it should also be possible to enable him to adjust extramurally, and the period for bringing this about should be as short as possible. Life in hospital should not be so easy and protective that a patient, when he is capable of understanding his own position, would wish to remain there.

The evidence available from various investigations shows that the period of hospitalization of mental patients should be neither too short nor too long. To determine the exact point at which it should end is the province of the psychiatrist. It will be too short if it ends before the patient is judged, on the basis both of his hospital conduct and of the general progress of his disease, capable of adjustment to community life; it is too long if the patient becomes so inured to his new life that he loses initiative and is not interested in discharge or in being given any opportunity for making an adjustment even within the hospital.

Professional hospital care, while the mental patient is in

hospital, should be intense. Crossman and Myers,[1] studying the effects of long hospitalization, express the opinion that among psychotic cases intense professional treatment not only is most effective in bringing about improvement, but results in a diminution of the period of hospital stay. On the other hand, Vaux[2] remarks that "cases of long duration [in hospital] whose active psychotic symptoms have long since subsided often deteriorate to a point where they resemble the mental defective in behavior and seem to require no more care than the latter." There seems little doubt but that psychotic symptoms have a tendency to become intensified and the patients to deteriorate mentally under routine long hospitalization. Wwedensky[3] reports two cases, and cites others, in which he observed reactivated psychoses become intensified and permanent under prolonged hospitalization.

With regard to discharging mental patients too early or "against medical advice," Klein and Cohen[4] in 1927 studied 285 such cases discharged from St. Elizabeths Hospital. Of 162 patients who could be followed, 18 had died from natural causes without readmission to a mental hospital. Eighty-seven per cent had been unable to adjust to normal community life, and 74 per cent of these had had to be rehospitalized. Only a small percentage had been able to make a more or less satisfactory adjustment to society. In 1929 Wertham[5] reported upon 193 patients voluntarily admitted to the Henry Phipps Psychiatric Clinic of the Johns Hopkins Hospital who had been discharged "against medical advice." Of these, 172 were followed, of whom 64 had apparently made satisfactory adjustments outside the mental hospital; 60 had

[1] "The Neuropsychiatric Problem in the U. S. Veterans' Bureau," by E. O. Crossman, M.D., and G. E. Myers, M.D. *Journal of the American Medical Association*, Vol. 94, pp. 473–78, February 15, 1930.

[2] "New Developments in the Care and Training of Mental Defectives," by C. I. Vaux, M.D. *Psychiatric Quarterly*, Vol. 7, pp. 672–81, October, 1933.

[3] "*Zur Frage der Endzustände Nach Reaktiven Psychosen*," by I. N. Wwedensky. *Zeitschrift für die gesamte Neurologie und Psychiatrie*, Vol. 200–16, 1928.

[4] *Careers of Patients Discharged Against Medical Advice From St. Elizabeths Hospital, 1920–1925*, by Elmer Klein, M.D., and Roger S. Cohen, M.D. MENTAL HYGIENE, Vol. 11, pp. 357–68, April, 1927.

[5] *Discharges Against Advice From a Psychiatric Hospital With Only Voluntary Admissions*, by F. I. Wertham, M.D. MENTAL HYGIENE, Vol. 13, pp. 564–90, July, 1929.

been readmitted to mental hospitals; 8 had made suicidal attempts. Kasanin and Cook,[1] of the Boston Psychopathic Hospital, in 1931 published a report of a five-year follow-up of 100 cases discharged "against medical advice." About half of these patients were schizophrenics or manic-depressives; the number of organic psychoses was small. Of the 100, 4 died in state hospitals and 11 in communities; 36 remained in community life; 44 were readmitted to mental hospitals; 5 cases were not traced. Of the 44 readmitted cases, 16 were subsequently discharged to the community. The percentage of schizophrenics able to adjust was only about half that of the other psychoses. At the time of report, 52 of the original 100 patients were living a community life.

It will be observed that even under the unfavorable circumstances of being "discharged against medical advice," a fair percentage of the patients were able to adjust on discharge.

Before taking up the question of deliberate medical discharge on parole, trial visits, or otherwise, we may for a moment glance at some aspects of the hospital life of mental patients and how long this should last. As Clarke[2] says, there is a tendency on the part of the hospital to continue a patient in a groove to which he has adjusted and in a place in which he may be of economic value to the hospital. This attitude is inexcusable, as it loses sight of the purpose of the hospital. The aim of the hospital should be to get the patient out of it and, as Clarke says, the occupational therapy in the hospital should be in line with the work the patient will do after parole or discharge, especially if he has confidence in his own ability to do such work. While the mental hospital itself cannot be made a highly specialized workshop center, yet its aim should be to keep the patient's mind orientated always toward the day of discharge to community life and he should be encouraged in ideas of self-dependence. Routine and absence of responsibility are the worst features of present-day mental-hospital therapy.

[1] *A Study of One Hundred Cases Discharged "Against Advice" From the Boston Psychopathic Hospital in 1925*, by J. Kasanin, M.D., and E. C. Cook. MENTAL HYGIENE, Vol. 15, pp. 155–71, January, 1931.

[2] "The Parole of Mental Patients," by H. G. Clarke, M.D. *U. S. Veterans' Bureau Medical Bulletin*, Vol. 3, pp. 124–27, February, 1927.

Reed and Nerancy[1] point out that *directed* occupational therapy in mental hospitals tends to become merely ritualistic in the absence of thoughtful medical attention. Patients are consigned to this therapy without careful attention and follow-up. Their activities and decisions are planned for them. These writers think that the time has come to bridge the arbitrary gap between occupational therapy in the hospital and industrial occupation on discharge. I personally am of the opinion that such a stepping-stone between the hospital and the home is highly desirable if it can be provided—a place in which the patient, while under limited supervision, is not under constant control; where he is provided with some kind of suitable work, is allowed to rely upon his own resources, and is suitably rewarded or compensated for his efforts. While it is not my purpose here to formulate any scheme, it might be possible to utilize some modification of the boarding-out plan, with elimination of its undesirable features.

To turn now to the question of the expectation of hospital life of mental patients, in 1925 Pollock[2] remarked that it had long been observed that the first year of hospital life is the most critical period in the life history of most patients with mental disease, but that ordinary hospital statistics throw little light on the matter. However, very definite data were furnished by Fuller and Johnston[3] in 1931. These investigators found that the majority of mental patients are in hospital either a very short time or a very long time. A statistical study made by them showed that 51 per cent of first admissions to the civil state hospitals in New York State had less than one year's total hospital residence; 13 per cent were in hospital sixteen years or longer. Of those patients with less than one year of hospital life, four-eighths were

[1] "Modern Hospital Treatment of the Psychotic; An Attempt at an Evaluation of Present and Future Trends" by C. F. Reed, M.D., and J. T. Nerancy, M.D. *Journal of the American Medical Association*, Vol. 104, pp. 292–97, January 26, 1935.

[2] "What Happens to Patients with Mental Disease During the First Year of Hospital Life," by Horatio M. Pollock. *State Hospital Quarterly*, Vol. 10, pp. 594–608, August, 1925.

[3] "The Duration of Hospital Life for Mental Patients," by R. C. Fuller and Mary Johnston. *Psychiatric Quarterly*, Vol. 5, pp. 341–52, April, 1931.

discharged as recovered, much improved, or improved; one-eighth were discharged unimproved; three-eighths died in hospital. Their study included 37,000 first admissions of psychotic patients during three selected periods of two years each. The psychoses included manic-depressive, dementia praecox, senile, arteriosclerosis, alcoholic, general paralysis, and "other psychoses." Dementia-praecox and manic-depressive psychosis were the two largest differentiated groups. The tables and charts published by these authors show that 59.7 per cent of first admissions during the first selection period, 62.3 per cent of those during the second, and 65.1 per cent of those during that third spent less than a year in hospital.

Of 10,149 dementia-praecox and 6,320 manic-depressive cases whose histories were known for a sixteen-year period, out of every 100 first admissions 35 had been discharged with favorable outcome, 7 had been discharged unimproved, 42 had died in some mental hospital, and 16 were still in some mental hospital. It was only among the manic-depressive, alcoholic, and "other psychoses" groups that high percentages of favorable outcomes were found. Manic-depressives and dementia-praecox cases were the only two psychoses that had any large number of hospital repeaters. There were a larger number of successful outcomes among the "one-hospital-residence" cases than among repeaters.

In only four of the seven groups studied—alcoholics, manic-depressives, "other psychoses," and dementia praecox—were there found to be at least 25 per cent of first admissions with a favorable report on discharge.

For approximately 51 per cent of all first admissions, hospital life was over within one year. For first admissions of the "favorable-outcome" group, this was true of over 72 per cent of the cases.

The authors express the opinion that if there is to be discharge with a recorded condition of improvement or recovery, this is likely to occur after a short stay within hospital walls, in most diagnosed cases within a duration period of only a few months. The records show that the likelihood of discharge with a favorable outcome decreased rapidly as the duration of hospital life increased.

A previous study by Fuller,[1] covering a period of more than eighteen years after first admissions, had shown that nearly three-fourths of all psychotic patients were out of hospital at the end of five years after first admission. The point at which the number of patients in hospital equaled the number out of hospital was reached in less than nine months in the case of manic-depressives, but not until after five years in dementia-praecox cases. Manic-depressives, however, showed the largest percentages of readmissions at the end of a fifteen-year period of observation. In every psychotic group there was a greater reduction in the number of patients "in hospital" during the first year after admission than there was during the succeeding fourteen years. The early drop was sharpest in the first year, but continued with considerable rapidity to the end of the second year and at a lesser rate to the end of the fifth year. From that time on, the reduction was extremely slow for the general-paralysis and manic groups. For all psychoses, the rate of reduction was much slower during the second five-year period than during the first, and during the third five-year period than during the second. The number and proportion of permanent eliminations by discharge during fifteen years of observation were greatest with manic-depressives and alcoholics and least with the senile, arteriosclerosis, and general-paralysis patients.

In the senile, arteriosclerosis, manic-depressive, alcoholic, and "all psychoses" groups, more than half of the total final discharges occurring in fifteen years had occurred by the end of nine months; in dementia-praecox by the end of a year. More than three-fourths of the final discharges had occurred by the end of two years. This suggests, the author thinks, that permanent recovery is a matter of the early part of hospital life.

From the results of the foregoing investigations, one is fairly entitled to conclude that long hospitalization is detrimental to psychotic patients in general and that the longer the hospitalization, the greater is the detriment.

The query then arises: How is the hospitalized mental patient to be disposed of when it is judged expedient that he

[1] "Expectation of Hospital Life and Outcome for Mental Patients on First Admission," by R. G. Fuller. *Psychiatric Quarterly*, Vol. 4, pp. 295–323, April, 1930.

be dismissed as no longer needing active hospital care? That is to say, should he be boarded out, paroled on a trial visit to his home or community for a limited period, or sent to a supervised colony which is really a convalescent annex of the mental hospital?

The history of boarding out psychotic patients in Belgium (Gheel), Scotland, Massachusetts, and elsewhere is very well known. The main general objection to this method is that as a rule the boarding-house keepers take no interest in the patients other than caring for them on a paying basis, and the patients have no great interest in adjusting themselves. On the other hand, where there is medical supervision, some patients adjust very well, chronic patients are less liable to deteriorate mentally than in hospital wards, and the method gives an opportunity for placement of a patient without returning him to his own home, where there may be personal and familial problems and entanglements. Economically, the patient is still a burden to the state.

In all probability boarding-out in some form, whether in a private family, a regularly supervised boarding house for such special patients, or the patient's home, will continue for that type of chronic psychotic who no longer needs hospital treatment, but is incapable of becoming self-supporting. It will meet the problem of long hospitalization in many instances.

Regarding parole and trial visits to home or community, Clarke,[1] writing in 1927 from the Knoxville, Iowa, U. S. Veterans Hospital, stated that during the past fiscal year 60 mental patients had been sent home on trial visits for periods of from thirty to ninety days. Of these patients 26 were returned for further hospitalization, as they did not adjust well to home conditions although all had made good hospital adjustments; 20 were discharged; and 14 were still on parole. The author thinks that the period of trial visit was too short, and suggests a year.

In 1930 Leslie,[2] of the Perry Point, Maryland, U. S. Veterans Hospital, wrote on the same question. Leslie states that, owing to the paucity of published information, he was

[1] "Parole of Mental Patients," by H. G. Clarke, M.D. *U. S. Veterans' Bureau Medical Bulletin*, Vol. 3, pp. 124–27, February, 1927.

[2] "Extramural Care of the Mentally Sick," by F. E. Leslie, M.D. *U. S. Veterans' Bureau Medical Bulletin*, Vol. 6, pp. 943–49, November, 1930.

obliged to get the required data regarding trial visits from the veterans hospitals direct and from other sources both in the United States and foreign. The collected data showed that the percentage of patients on trial visits from state hospitals in the United States varies from 3 to 25 per cent, depending largely on the degree of community supervision it is possible to administer through hospital physicians and social workers. The length of such trial visits varies from one year to an indefinite time.

The U. S. Veterans Hospital, Perry Point, Maryland, granted trial visits to 495 patients during 1929; 126 were discharged as improved.

The author cites the paper by Crossman and Myers already referred to [1] which gives very interesting data. At the end of the fiscal year 1928, U. S. veterans hospitals had practically 13,000 patients under treatment for mental disease. During the year 11,454 were admitted and 11,118 were discharged after hospital treatment for some neuropsychiatric disease; 3,500 were psychotic. While no figures are given to show the number of patients on trial visits, it seems reasonable to presume that at least 1,000 of the psychotic group were discharged only after a try-out period of community adaption. Dr. Crossman, who was Medical Director of the U. S. Veterans' Bureau, stated that investigation of the home situation before grant of trial visits was being made in an increasing number of instances and that the supervision of patients in the community presented the greatest challenge to the Bureau's psychiatric social workers.

Leslie cites also the experience of Dr. Kolb, at Erlangen, Germany, with community trial visits of psychotic patients. Dr. Kolb is said to have had, during the years since the World War, 3,000 patients under his direct medical supervision in the community. He had hospital accommodations for only 800. It is stated that he began the experiment of trial visits with misgivings because he was afraid that there would be suicides, homicides, and innumerable difficulties. His fears were found to be unjustified, and he satisfied himself that community care excels institutional care from every point of view—therapeutic, economic, and social.

Regarding the discharge of psychotic patients from mental

[1] See Note 1, page 568.

hospitals to some supervised colony, camp, or home intermediate between the hospital and the regular home or community, I have already briefly alluded to the desirability of such a method. I do not know of anything of the kind in actual practice, but I think the idea worth considering on the ground of economy, though more especially from the point of view of therapeutic advantage to the patient. I will not attempt in this paper to suggest any of the details of such a stepping-stone policy in the treatment of mental patients. I think that the figures cited above regarding the high percentage of patients who adjust even in the face of unsatisfactory trial visits would be much increased if some place were provided where they could personally find themselves before again being turned loose into ordinary community life. Furthermore, I am of the opinion that a policy of more rigorous professional hospital therapy and rapid discharge is indicated in the affective psychic disorders and that, if pursued, it would lead to more frequent permanent recoveries or readjustments.

The final matter to which I wish to refer to is, What becomes of the mental patient after his discharge from hospital? Here I must quote from another article by Fuller,[1] published in 1935.

Fuller gives the following tabulated summary showing the outcome in the cases of 947 patients discharged from the civil state hospitals of New York during ten years from date of discharge:

	Male	*Female*	*Total*	
	Number	Number	Number	Per cent
In community continuously	146	248	394	41.6
In community after readmission at some time	57	65	122	12.9
In civil state hospital	72	118	190	20.1
In other mental hospitals	7	6	13	1.4
In other institutions	1	5	6	0.6
Died in community without readmission to mental hospital	69	67	136	14.4
Died in community after readmission to mental hospital	9	6	15	1.6
Died in civil state hospitals	37	31	68	7.2
Died in other mental hospitals	1	2	3	.3
	399	548	947	100.1

[1] "What Happens to Mental Patients After Discharge from Hospital?" by R. G. Fuller. *Psychiatric Quarterly*, Vol. 9, pp. 95–104, January, 1935.

A matter of considerable importance is the hospital supervision of all discharged psychotic patients, whether discharged finally or on trial visits to their homes.

The social aspects of the mental patient's discharge into his home and the community are also significant and point to the need for careful study of his adjustment. Too often the institution "washes its hands" completely of the problem when the patient leaves the hospital and the patient's family is left to cope with the situation alone, in bewildered ignorance as to how to be most helpful to him. Often his presence and symptomatic behavior cause serious discouragement, with resulting delinquency and breakdown in the family. The following case, which is only one of several that I could cite, is an illustration of this:

> Mr. R., thirty-eight years old and the father of four children, had been developing increasingly serious symptoms of behavior over a period of eight years. Before his commitment his children were showing the effects of the disturbed home life. The fifteen-year-old daughter, who could not bring any of her school friends to her home because of her embarrassment at her father's unusual behavior and indiscreet remarks, was seeking all of her companionship outside, often remaining away until late at night. The nine-year-old boy, who loved as well as feared his father, was so troubled and hurt by his erratic behavior that he had turned to acts of petty stealing which had resulted in several juvenile-court appearances. The patient's harassed and discouraged wife had become so disturbed over the home situation and her husband's behavior that she had lost all interest in living and retired more and more into a tense silence. She was, therefore, at a loss how to help the children in any way and the home was on the point of break-up when Mr. R. was finally committed to a mental hospital. A diagnosis of dementia praecox, paranoid type, was made, and the patient remained in the hospital eight months.
>
> During the time that he was in the institution, the entire home situation changed. With additional recreational opportunities offered to the children, they had become much more normal, happy youngsters. They were able to take an interest in their home, which had become a place where they could have some pleasure, some chance for self-expression and the companionship of their friends. A social agency, which was interested in the family during this time, noticed a definite improvement, too, in the mother's attitude toward life. She was able to talk out her feelings about her husband and his condition, took a renewed interest in the home and in the children, and because she had time to have some needed physical care for herself, was on the way to becoming an adequate person once more.
>
> At the end of eight months Mr. R. was released for a week-end trial visit. He was offered a job and asked further leave to remain at home and take this work. Permission was granted by the hospital without any further consideration of the matter, or without any discussion with

the members of the family as to what it would mean to them to have the father again in the family group. Because the hospital agreed to the plan, the family accepted him as a "cured person." They were given no suggestions as to how he might best be helped to reënter the family life. The children were not stimulated to an attitude of helpfulness toward their father's problems, and in a very short time a recurrence of his difficult behavior so upset the entire family that they individually returned to their earlier asocial behavior. The woman, discovering that her husband was not "cured," became so discouraged that she again retreated into her despairing silence. When she found that she had become pregnant, she was so frantic that she aborted herself and nearly died from the resulting infection. The younger boy returned to his stealing, and the girl left home entirely, making arrangements to live with relatives in another city.

If the hospital physician had been able to observe the man's behavior in the home, and if some interpretation had been given to the family as to what they might expect from the husband and father, it is possible that their understanding might have stimulated them to an effort to help him. Follow-up by a social worker under the hospital's supervision might possibly have resulted in the decision that the man was not ready to be released to his home at this time. The cost to the individual family and to the community at large of the release of this mental patient without supervision and follow-up was great and will be far-reaching.

To summarize briefly, the following conclusions derived from a consideration of the problem of hospitalization for mental patients seem important:

1. Hospitalization that is too prolonged is very apt to be detrimental to the mental patient—and is not the only solution to the problem of his care.

2. The first year of hospital care is the most significant and important in the treatment of the psychotic. This period, therefore, should include careful study of the patient, frequent evaluation of his reactions to institutional life, and a plan of occupational therapy worked out with him which will stimulate his sense of responsibility, allow for freedom of choice on his part according to his expressed interests, and proceed always on a progressive basis as he is able to assume more and more responsibility. The institution so easily becomes the "good mother" to the patient, the protective environment that provides for him and relieves him of any need for initiative, that everything possible should be done to counteract this tendency. It should offer him opportunity and stimulation to make successfully simple adjustments within the institution on a continually progressive scale, with

recognition sufficient to give him increasing satisfaction in his own development. Occupational therapy, then, should be a constantly changing program for him, with as little deadening routine as possible.

3. Trial visits to his home should be arranged for the patient only after a study of the environment to which he must return, with interpretations and suggestions to his family, so that his reassimilation into the home atmosphere may be accomplished with the most benefit to him and the least possible disturbance and injury to the life of other members of the group.

There should be continual observation and follow-up during the period of these visits, preferably by psychiatric social workers working under the supervision of the hospital physician.

4. Further experiments with the system of boarding out might eliminate some of the disadvantages of the projects already attempted in this field. It has great possibilities as a planned environment for bridging the gap between the hospital and entrance into community life. While providing greater freedom for the patient, it, too, should be accompanied by constant supervision — preferably so conducted that the patient is little aware of it—and the boarding home should be directed by trained individuals whose main concern is a professional interest in the patient's rehabilitation rather than an interest based solely on economic profits.

THE ORGANIZATION OF STATE-HOSPITAL CHILD-GUIDANCE CLINICS

FRANK F. TALLMAN, M.D.
Senior Assistant Physician, Rockland State Hospital, Orangeburg, New York

WHEN the mental-hygiene movement began, it very necessarily concerned itself with the care and treatment of individuals who, because of mental disease or mental deficiency, had become problems to society. At the present time these people are being, on the whole, well taken care of, at least in so far as their physical comfort is concerned. That the progress of mental therapeutics, from the standpoint of prophylaxis, has not kept pace with brick, steel, and concrete construction is not because mental hygiene, in the broad sense, is faulty in its conception. It is rather that mental hygiene has never been adequately tried.

It is worth mentioning, in passing, that while parole clinics are in a sense mental-hygiene clinics, they are continually faced with what, for the present, would seem to be unsolvable problems. One situation is this: An individual becomes so maladjusted as to require hospitalization, or, to restate it in other terms, a poorly integrated personality has met with some exciting cause too much for it to withstand. This cause may be marital disturbance, a complicated family situation, a failure in vocational endeavor, or, more recently and more seriously, unemployment. The patient goes to the modern hospital and is thereby immediately, but temporarily, removed from some of his problems. He has the benefit of comfortable living quarters, proper care of his health, occupational therapy, and some individual psychotherapy. The personality recovers its balance. After a pre-parole investigation, which is more or less a summing up of his problem and previous social and economic status, he is paroled back to the same family situation, the same vocational failure, or the same unemployment. It is obvious from what has just been said that mental hygiene in this case has not had a

chance to demonstrate either its efficiency or its failure. That a reasonable number of patients remain out is a real tribute to the institution from which they have come, or perhaps rather a tribute to the innate adjustability and flexibility of the human being.

All this may seem a long way from the discussion of a child-guidance-clinic organization with the state hospital as its center, but it is more pertinent than it seems in as much as it contained a reference to social organization and also to a personality poorly integrated. Mental hygiene concerns itself not only with personality development, but, in a growing measure, with social practice and philosophy. It is time that the state hospital became more fully aware of its duties and responsibilities in the matter of the mental-hygiene movement. It must do more than advise about the problem child. It must become a force in the community through *action,* with the clinic as a base of operation. It must advise about the normal child.

No one denies the need of a budget of millions for the care and attempted rehabilitation of individuals who have already become serious problems, but these millions are being spent when it is too late. It is as if in a flood-control program all the money allotted to the engineering department were being used to buy hose and pumps to keep the land dry, leaving none for building a dam to control the flood at its source. It would seem that the budget for preventive measures should be very substantially increased, so that the principles and, more important still, the *practices* of mental hygiene may be given a fair trial by the people who are, by training and experience, best fitted for the work. As things now stand, the money spent by most state-hospital systems in mental-hygiene work is so small a percentage of the total budget that not sufficient time is purchased even to scratch the surface. Despite the handicaps, certain hospitals are making great strides because of the attitude and sympathetic support of their superintendents, but even these are constantly being hampered through lack of personnel. The cost of adequate personnel would mean a further drain upon the taxpayer, but if one were to listen to the general public too closely, one would be forced to go back to the purely custodial days. The surpris-

ing thing is that when the public gets mental hygiene, it likes it, wants more, and is willing to pay for it.

What mental hygiene is able to do should not be overstated. It is easy to say that mental hygiene and child guidance are not panaceas for mental illness. It is easy to point out that organic mental diseases form a large part of our hospital admissions. It is just as easy and equally truthful to state that children should and could have an opportunity to live in an environment that is conducive to the full development of their intellectual, emotional, and social potentialities. This having been stated, there must be machinery at hand to back up the statement. Even if it is found that first admissions do not decrease, that will not mean failure, for a great deal will have been added to human adjustment, to the art of living, and to social order. In other words, it may be necessary to go on spending as much money pumping as before, but the people who inhabit the dry land will certainly, unless our psychiatric thought is entirely wrong, be better, happier, and mentally stronger humans. Certainly the need of an increased personnel really to try out our beliefs is vitally necessary. The time for merely lecturing and writing pamphlets has passed.

When special knowledge exists, it should be used by all the organizations that require that special knowledge. If this is so, then the state hospital is in a key position to become the cultural center, in so far as matters mental are concerned, in the community in which it exists. It has within its microcosm all the special knowledge in this field needed by the community that surrounds its walls. In other words we have here great potential energy waiting to be released for prophylactic activities.

In any community there are health facilities, schools, religious organizations, social agencies, courts, service clubs, Boy Scouts, recreational facilities, Y.M.C.A.'s, and numerous other social organizations that deal with individuals of all ages and kinds. All these teachers, preachers, leaders, directors, physicians, club members, and so forth, are affecting for good or ill the adults and children with whom they come in contact.

People need not be psychiatrists, psychologists, psychoan-

alysts, or profound students of dynamic psychiatry to practice a reasonable mental hygiene in respect to themselves and their charges. There is no more conscious exponent of caution in the matter of public psychiatric education than the present writer, but it is possible to be so fearfully cautious that all activity ceases and dry rot sets in. It seems idle, however, to worry much about who shall and who shall not practice mental hygiene. Whether we like it or not, everybody who is interested in people is practicing mental hygiene of a sort. A lot of it is fair, some of it is fairly poor, a great deal of it is very bad. This is because psychiatrists as a group have not taken the trouble really to educate their communities in the proper *use* of knowledge with which they have become familiar through the popular press. The fault, of course, is not theirs. Any damage that has been done has been done by progressive people who tried to fill a need that psychiatrists, in their scientific zeal, have shamefully neglected and sometimes openly spurned.

It would be easy to change this. It would be easy to make psychiatrists again the leaders of mental-hygiene thought and practice. The state hospital should and can do this. It has but to supply the personnel needed to educate the community, not by more or less academic and philosophical discussions, but by entertaining lectures backed by a real program that can be put into effect.

Mental-hygiene books and pamphlets of all types issued by organizations, individuals, and institutions have made the public rather surprisingly conscious of the subject. It has made some people too introspective and this is bad, but it has made others individual-conscious and this is good, provided there is at hand knowledge of what to do about it. For example, a teacher who knows anything at all of the mental-hygiene concept does not look upon her pupils as classes and her school as a knowledge factory. She considers the pupils as individuals who must be taught to live and who must be given an opportunity to integrate into a smoothly functioning whole the potentialities with which they were born. Now, a teacher with this concept is either a serious liability or an exceptionally fine asset to her school and to society. If she knows only that people are important and interesting, she is

very likely to be a liability, but if she has had an opportunity to get her knowledge from a source that is authoritative and practical, she is likely to be an asset.

It is the duty, then, of the state hospital, as the community center of psychiatric culture, to initiate a program that will combine education and practice, beginning with the child and ending with community life as a whole.

Let us start with the head of the clinic organization, the director. A full-time physician must be placed in charge right at the start. The correctness of this assertion will be appreciated by all those who have tried to run hospital services and clinics at the same time. It is no economy to expect the director to be in charge of an inside service, too. When this happens, neither function is performed up to capacity. Since the extramural psychiatrist is in contact with the outside world and is in a sense the interpreter of the institution to the community, he must use a good deal of tact or else the reputation of the hospital and his own program will suffer. Some have said that institutional psychiatrists are unsuitable for this work because they have lived too long in a system that is necessarily more or less rigid. Others make the criticism that state-hospital men have had too much responsibility coupled with too little real authority and, as a result of this modified form of over-protection, have become incapable of independent leadership. This is rarely so—state hospitals have people who not only are interested in the work, but have the administrative ability necessary to carry it out.

The next indispensable individual in the set-up is a psychologist. The writer has become convinced that the social worker who has been taught a few fundamentals of psychometry may be a liability to the clinic. Psychometry offers enough problems in itself even when it is properly done without utilizing improperly trained people to do it. Most state hospitals have no provision for psychologists. A determined effort by superintendents should be made to have them included. Too often, the psychologist is a volunteer or is working for attendant's pay. The psychologist should have the same rating and the same pay as a social worker.

The organization is now ready to function. Growth will

soon make necessary the addition of another doctor, on part time at first. He should not be in charge of a hospital service, but should be so placed in the institution that his absence when he is away at clinics will not be a disturbing factor. As time goes on, he, too, will be absorbed on a full-time basis and if it has been really decided to go ahead on a practical and expanding plan, a third will soon join the ranks. The writer feels that it would be a good procedure to have at least one of the child-guidance items on a rotating basis in order that as many staff members as possible may receive training in work of this nature. *It would help to put the hospital into the community, not on the community.*

Thus far, nothing has been said about social service in the clinic organization. Many clinics do not have within their own organization any really adequate system of follow-up. They are dependent upon the referring agency which, incidentally, always has too much to do in caring for its own case load. If it is a good policy to have social workers for the purpose of assisting parole patients in adjustment, certainly it ought to be a still better one to have them functioning on the preventive end of the state-hospital set-up.

The next question that comes up is the matter of records. No one denies that records must be kept, but often too much time is spent in laboriously writing out findings, interpretations, and recommendations. The easiest way to get rid of this time-wasting nuisance is to have competent stenographers go into the field with the clinic. The result will be time saved and better records. The doctor will dictate a better report than he will write, and surely a doctor's time is more valuable than that of a stenographer. This is especially true if the doctor has many busy clinics and little office time.

The source of intake must be considered also. Where are clinics to be held? The trite answer to that is: In all organizations handling human material that want and can profitably use the service. This includes general hospitals, social agencies, health centers, courts, and especially schools. In a more general sense, assistance can be given on a consultant basis to organizations like the Boy Scouts and the Y.M.C.A.

The case load is worthy of mention. Unless one is very

careful, one tries to do too much, with the result that efficiency is sacrificed. The load should be no more than four cases a day. It is rarely that this standard can be kept, but no more than five, including return cases, should be at the clinic in one day.

At this point it is necessary to discuss treatment. At clinics of this nature it is impossible to do a laboratory job. Occasionally a case can be worked with fairly intensively by the psychiatrist, and no matter what his psychiatric theories, his technique will be peculiarly his own. If he is passive and objective, if he neither praises nor blames, and if he has a sense of humor, his technique will not be far wrong. Treatment, then, will be carried out by people in the child's environment, such as parents, nurses, teachers, or social workers.

There is a serious deficiency in many existing set-ups. Not nearly enough time is given to consultations, discussions, and case conferences. The organization itself ought to have weekly or at least bi-weekly meetings to discuss policy, procedure, and cases. Monthly meetings, to which are invited representatives of the organizations with which the clinic works, should be held. Case material can be used for teaching purposes, and the community will also have an opportunity to tell the clinic what services need to be modified in accordance with the peculiar interests or resources of the community. Thus will the all-important coöperative spirit be strengthened.

We have sketched the mechanics of organization. There now remains the matter of policy, which, after all, is perhaps the most important factor in the whole situation. I believe that the extramural program should center about the child-guidance clinic. The personality of the child is malleable. He is receptive to environmental and attitude therapy, and time spent with him is likely to be productive of lasting good. Of importance is the fact that the clinic will serve as a logical center for the dissemination of mental hygiene through all the community activities, but it is wise to lay down an organization for practicing mental hygiene before too much public education and propagandizing is done. It is much better to do this first than to "point with pride," so to speak, and then frantically search for results.

When a psychiatrist enters upon a community program, he is always full of enthusiasm and, if he is not careful, he tries to force his beliefs upon the organizations with which and in which he works. This is a bad mistake. While it is true that the psychiatrist has special knowledge which has to do with the development of a personality capable of the "full life," it is, nevertheless, true that he has not the answer to all community problems.

As a matter of policy, the technique of one's approach is important. For example, unless one pauses to think when discussing a mental-hygiene program with a school official, one is inclined to make the plain statement that the school is badly in need of a clinic and then to offer such services as can be given. This is not the best way to approach the problem. The school man is likely to react as he does to his insurance broker—get negativistic and on the defensive. The thing to do is to express an interest in *his* organization and, by questions, find out what is being attempted. Then one is in a position really to be of use. This passive technique immediately creates a sympathetic interest. People are greatly relieved to meet some one who will ask questions. They are so used to prophets who supply all the answers first. Thus, through an understanding of the other fellow's problem, the psychiatrist is saved from misunderstandings of policy and ridiculously impractical recommendations. Too often, the psychiatrist is dogmatic in his judgments of what ought to be done. He himself doesn't show the adjustability that he expects to find and tries to inculcate in others. Recommendations may be beautifully scientific, couched in the most approved psychiatric language, but yet be of no value because the recipient is unable to carry them out, even though he does understand them. The more information and help the mental-hygienist asks from others, the more the principles for which he stands will infiltrate the organization in which he works and of which he must be a part. As this infiltration is being accomplished, the court, the social agency, the school, the health clinic will see that the principles of mental hygiene and, more specifically, the child-guidance attitude, are fundamental concepts and are vital to any agency that handles human material.

Educators are more and more coming to the firm conviction that the importance of education is not so much the imparting of knowledge as it is the imparting of a way of life. With this thought in view, they are trying to broaden the base of the whole system, planning to have nursery schools at the beginning and practical adult-education courses at the end. They are now interested in people as personalities which have potentialities for disintegration just as they have potentialities for integration. The more one contemplates definitions of mental hygiene, the more one is forced to the conclusion that mental hygiene also is concerned with providing an environment calculated to assist in the development of a personality that can fully utilize its potentialities for mature intellectual, emotional, and social growth. The parallel is obvious. Educators have begun *their* expansion. Is there not in their behavior a lesson for mental hygienists? We must broaden our base of operations, with state-hospital child-guidance clinics at one end, and at the other, a parole system more sensitive to social situations.

Conclusions

1. It is necessary to reëmphasize the importance of a preventive program centering around state-hospital child-guidance clinics.

2. Mental hygiene should be given a fair trial. To do this an adequate budget must be provided for personnel.

3. The state hospital is the logical center in the community for the dissemination of mental-hygiene knowledge.

4. Child-guidance clinics are excellent foci for the spread of mental-hygiene theory and practice into all community activities that have to do with people.

GROUP PSYCHOLOGICAL TRAINING IN SOME ORGANIC CONDITIONS

M. N. CHAPPELL, PH.D.
Department of Psychology, Columbia University, New York City
T. IRVING STEVENSON, PH.D.
Group Psychological Research, New York City

IN recent years, and most especially since the onset of the depression, it has become increasingly apparent that emotion and worry play a very important part in the initiation and prolongation of some forms of organic disease. Physicians have been especially impressed with the extent to which worrying prevents a rapid recovery in persons suffering from peptic ulcer. The part played by the emotions in such conditions as the anxiety "neurosis" or "nervous breakdown" have long been recognized. Now it becomes apparent that even in the pains of arthritis psychological factors are important.

During the past four years, each of the conditions mentioned above was investigated in collaboration with one or more metropolitan physicians. In each case the patients received medical attention coincidentally with the psychological training. The psychological training represented a departure from prevalent methods in that the patients were taken in classes ranging in size from five to twenty-five, receiving daily instruction for periods that varied from four to eight weeks according to the requirements of the disorder. The results of the psychological training were uniformly good, especially those obtained with severe peptic ulcer and the more functional constipation and anxiety conditions.

As a result of these investigations, Group Psychological Research was established on a private grant, to run for at least two years. This work is under the direction of the authors of this paper, in collaboration with the gastroenterologists of some of the metropolitan hospitals. The classes are open not only to the clinic patients of these hospitals, but to any one whose physician may recommend him. No one may attend the classes who is not in the hands of some medical

doctor or clinic. The psychological training is not a substitute for medical treatment; it is supplementary. The classes are at present restricted largely to gastrointestinal disturbances. It is hoped that in the next two years, evidence will be obtained on many hundreds of cases.

The project was established not only to apply psychological training procedures to those disorders that have already been investigated, but also to extend the investigations to other fields which physicians may deem to be promising. To this end Group Psychological Research is prepared to collaborate with any metropolitan physician connected with a public hospital in investigating the influence of psychological factors in organic diseases, exclusive of the psychoses or other disorders that involve loss of nervous control of the part affected. The nature of the work may best be understood by considering one of the experiments that have been carried on.

The first experiment ever performed[1] in which group psychological training was applied to an organic disorder was one arranged in the fall of 1932 to determine to what extent peptic ulcer is subject to psychological influences. This experiment represented the collaboration of a physiologist, Professor F. H. Pike; a gastroenterologist, J. J. Stefano, M.D.; and two psychologists, Mr. J. S. Rogerson and M. N. Chappell, Ph.D.[2]

The first problem encountered was that of obtaining groups of patients sufficiently large to give statistical reliability to any results that might be obtained. Mr. John O'Neal, who was then science editor of the *Brooklyn Daily Eagle* and is now with the *New York Herald Tribune*, solved this problem for us by publishing an article in the newspaper describing

[1] The excellent work with groups at the Boston Dispensary, described by Mr. Winfred Rhoades in the July, 1935, issue of MENTAL HYGIENE, represents "clinical" as opposed to "experimental" investigation. The difference is that the experiment is "controlled."

[2] The technical and more complete report of this experiment is being published elsewhere. Not all of the four experimenters agree with the interpretations given here. Dr. Stefano prefers to interpret the results in terms of the Freudian principles, while Mr. Rogerson is partial to the assumptions of the New Nancy School. Dr. Stefano has presented his interpretation in an article appearing in *The Medical Times and Long Island Medical Journal*, Vol. 64, pp. 72–74, March, 1936.

our interests and asking for volunteers. Two hundred subjects volunteered. On careful diagnosis, about one hundred and fifty of them were found to be suffering from either organic peptic ulcer or what may be called pseudo- or prepeptic ulcer. Fifty-two of those found to have organic conditions completed the experiment, as did thirty-nine of those who had no organic signs, but had all of the characteristic pains and some of the abnormal physiology. In this article only the fifty-two who had organic pathology will be considered.

All of the patients in this group had previously shown themselves to be resistant to successful treatment by the standard medical and dietary procedures. None was a new case; none was confined to bed; none was accepted in whom the ulcerous condition was deemed to require surgery. Only those cases which are commonly treated by medical therapy were permitted to participate in the experiment. All of the patients came from Brooklyn and Long Island communities. They were mostly men, but a few women were also included. The age varied from twenty-six to sixty-three years. The patients came from all walks of life, from unskilled labor to the professions. Business and professional people predominated. Seven nationalities were represented and the economic status varied from government relief to that of secure comfort.

All of the patients were diagnosed by Dr. Stefano according to the standards of medical practice. These include:

1. Complete medical history and physical examination.
2. Test meal for the determination of hydrochloric acid, total acid, mucus, and food retention.
3. Stool examination where it was deemed advisable.
4. Fluoroscopy following barium meal.
5. X-ray plates in doubtful cases.

All of these patients had the characteristic ulcer pains as well as some pathology. All had had at least one reliable diagnosis of peptic ulcer prior to their examination for the experiment. In some cases as many as six previous reliable diagnoses had been made.

These fifty-two subjects were put on a standard dietary and medical régime. The medication consisted of gastric mucin, a powdered extract of the mucous washings of pig

stomach. Its supposed function is to neutralize hyperacidity and eliminate pains. The essential features of the diet were frequent feedings of moderate amounts of foods consisting of the soft cereals, milk, and puréed vegetables. In some cases some form of alkali was given in conjunction with the gastric mucin.

The tests were made in the offices of Dr. Stefano and the subjects were treated by him as private patients, but without charge.

Now it is apparent that if all of these subjects were given both the medical treatment and the psychological training, there would be no way of knowing what part of the recovery was due to medication and diet, and what to the supplementary emotional education. To determine the influence of the education, a control group was employed. Instead of giving all the patients training, the fifty-two were divided into two groups, one of thirty-two and the other of twenty. The former, or "experimental," group was subjected to the procedures outlined below, and the latter, the "control" group, was not. There were, then, two groups of similar disorders, both of whom received the same medication and dietary treatment. The only difference was that one received emotional education and the other did not. By subtracting the recoveries obtained in the control group from those obtained in the experimental group, it was possible to determine with some accuracy the influence of the psychological training.

All differences between these groups were in favor of the control, as is shown in the following comparisons:

	Experimental group	*Control group*
Age:		
Range	26–63 years	27–59 years
Average	44 years	42 years
Period of peptic disorder:		
Range	2–30 years	2–25 years
Average	12 years	8 years
Period of recognized peptic ulcer:		
Range	2–21 years	1–25 years
Average	8 years	7 years
Previous surgical treatment for peptic ulcer	5	0
Previous reliable diagnoses of peptic ulcer:		
Range	1–6	1–4
Average	2.6	1.6

There was a marked similarity in the psychological behavior of these patients. There was nothing that they enjoyed more than to talk about their disorder, which they did on every possible occasion. They believed themselves to be subject to a condition from which recovery was very doubtful. They were frequently reminded of this by solicitous friends and relatives. Their whole life was organized about their disorder and much of their time was spent in dwelling on the difficulties connected with it and reviewing previous emotional experiences associated with it. They all tried to control one or another aspect of their disorder through "acts of will" or "will power." Fear of foods was developed to a high degree. They feared and dreaded pains in the stomach which might occur during the day or the night. They were highly irritable and were provoked to outbursts of anger by inconsequential situations. They all became fatigued easily. Their attitude towards the experiment was that it was just one more thing to try and that they would give it a good trial. None thought there was any very great probability that it would help him. They thoroughly understood that this was an experiment and that whether they would recover or not was a question that could be answered only by the results they obtained.

The experimental group of thirty-two subjects were trained daily, seven days a week, for a period of six weeks. The lectures were given to groups of from five to ten patients at one time, though there was no real need to keep the groups so small since little or no individual attention was given to the particular case of any individual and none of them was permitted to talk about himself even with the psychologist. Moreover, the factors important in the maintenance of the disorders were very similar in all case. Of course there were minor differences in the patients' experiences, but in the important things they were alike: they were all maintaining or increasing their emotional activity through discussion, worry, and effort—in short, through practice.

The common fears found in this group were those concerning food and cancer. The fear of food in itself is quite enough to result in spasm of the stomach and pain after the food is eaten. Because of the frequency with which pain had previously been associated with the eating of most foods,

the period in which the patient is getting back to a normal diet is a critical one. For this reason the patients were kept on the diet noted above for three weeks. In this period the training became sufficiently effective to rid them, in part, of many of their fears of food. Space does not permit even an outline of all of the subjects covered in the six weeks. Suffice it to say that there were very few aspects of the patient's daily life that were left untouched. Chiefly the lectures aimed to teach him the influence of thinking on his bodily processes. While most of them were familiar with the antics of the ouija board, it had not occurred to them that all thoughts tend to result in activity in some part of the body. The physiological changes which constitute the emotional activity were considered and the patients were shown how their symptoms—digestive disturbance, fatigue, proneness to fear and anger, decreased sexual activity, and constipation—were produced or maintained through the overactivity of the vital organs. The connections here are so clear and close that the patients immediately grasped the situation. They were also shown that worry, which is quite as physiological as it is psychological, tends to prevent the gastrointestinal tract from obtaining the rest that is essential if it is to heal itself.

To prevent worry, the patient was instructed to pick out some period of his life about which he had many not unpleasant recollections. Each time he found himself worrying about himself—which was many, many times a day in the early stages—he was to direct his thoughts to the period of his life that he had chosen and concern himself, as far as possible, with the events of that period. For most people the reminiscence of childhood experiences serves well for this purpose. Any other period may be used, or the patient may turn his attention to some aspect of his immediate physical environment. Each time he found himself worrying, he turned his attention to the activity that he had picked out for himself, and continued with it until his thoughts were again back on his bothersome situations, at which time he again turned to his chosen activity. The patient has no great facility in diverting his thoughts for the first few days and should not be discouraged on that account. As with everything that is learned, facility comes only with practice.

When a patient has had a gastrointestinal disturbance with numerous recurrences, it is to be expected that he will soon acquire the fear that he has cancer and that his medical doctor knows it, but, through kindness, is concealing the fact from him. He reasons about as follows: "I am a very sick man. I have something the matter with my stomach that the doctor can't fix. What is it that the doctor can't fix? The doctor can't fix cancer. Therefore, I must have cancer."

It was not difficult to dispel this fear, for once the patient saw exactly what physiological changes accompanied worry, he realized that there was a good reason why the doctor had not been able to "cure" him—that he had been making himself sick just about as fast as the medical treatment had tended to make him well. The realization that all of the others in the group had the same idea about their condition that he had about his tended also to dispel the fear of cancer.

The patients were told to seek the coöperation of their families in the elimination of all discussion about, and reminders of, their disturbances. The families coöperated in this readily.

An incident that happened in one case illustrates this, as well as the customary reactions of the family with regard to the patient's illness and eating habits. When this man started attending the lectures, he sent his wife to Florida, so that she would not be constantly reminding him of his condition (gastric ulcer), and instructed his daughter to pay no attention to what he might do and not to remind him of his illness in any way, by word, look, or gesture. One day about five weeks later, he picked up a doughnut in the presence of the daughter. Without thinking, she immediately said, "Don't eat that, Daddy."

With some show of belligerence, the father asked, "Why not?"

"Because," replied the daughter, after a slight hesitation, "the dog licked it."

The patients were taught much of the psychology of learning and forgetting. They learned how they initiated or maintained their disorders through the practice attained in worry, discussion, and effort, and how to aid their recovery through forgetting, which must occur as soon as the practice is stopped. With practice the emotional reaction involving

the vital organs occurred more easily and more frequently. But as with everything else that is learned, practice is required to keep the viscera in this excitable condition, and as soon as the patient failed to worry—that is to say, to practice—as much as he was accustomed to, which was many hours each day, he showed improvement. This material was taught through citing pertinent experiments and from relevant illustrations in everyday life.

At the end of three weeks of training in a group, at which time all but one of the thirty-two were free from subjective symptoms, an expansion of the diet was recommended. This expansion continued through the following three weeks, at the end of which time all but two of the experimental subjects were eating about anything they desired, for the first time in many years. At this time the training was stopped. Of the two exceptions, one did not choose to expand as rapidly as we recommended, preferring to take it more gradually. He recovered satisfactorily. The other showed no appreciable gain from the training, then or subsequently.

After one month on medication and diet, all of the members of the control group were free from subjective symptoms. The expansion of their diet was recommended at this time. Within two weeks all but two of the twenty had recurrence of symptoms as severe as the original conditions. Of these two, one would not expand his diet as was suggested.

No attempt was made to determine the objective signs at this time. This was first done at the end of eight months. Only one of the experimental subjects reported recurrence of symptoms as severe as the original condition in that period, while both of the "control" subjects who had been well at the end of the six weeks had serious recurrences within two months.

The observations made three years after the training are more significant.

Of the thirty-one experimental subjects who were well at the end of the training period, three could not be located. The findings on the remaining twenty-eight were as follows:

Ten had remained symptom-free throughout the three years. "Symptom-free" is defined as the condition in which symptoms have not returned even for a day.

Five had remained nearly symptom-free through the

period. The average number of recurrences for this group was 1.8 per year; the average length of the recurrence was 4.9 days; the symptoms were reported to be mild; all considered themselves to be in excellent health. This is probably about the amount of digestive disturbance suffered in the population at large, which is to say that these five were about normal.

Nine subjects reported numerous recurrences of mild symptoms. Two reported single recurrences of severe symptoms, attended by hemorrhage. The average length of the recurrences was about six days. All but two of these eleven considered themselves to be healthy and were completely confident of their ability to take care of any symptoms that might arise.

Two others had recurrence as severe as the original condition, from which they had not recovered when the three-year check-up was made.

When one considers that all of these patients were taken from that class of peptic ulcer who "do not get well," the results are somewhat impressive, but as expressed above they do not tell the whole story.

One of the interesting findings of the experiment was that what impressed the patients most was not that they had rid themselves of their symptoms, but that the world seemed so much more pleasant than it had a few weeks before. They were rid of their fatigue, their bodily difficulties, and their timidity and anger. They again had complete confidence in themselves and their abilities. They were again interested in the people and things about them. The world had lost its heavy grey shroud, and zest for life had returned.

These results, and others obtained in the investigation of other forms of disorder in which emotion plays an important part, indicate that some of the ideas commonly held concerning psychological influences in disease are sadly in error.

One of the ideas most prevalent is that psychological procedures can be of no aid to the patient unless he starts out with a belief in them. The following illustration may help to dispel this error:

H. N. had been subject to peptic ulcer for twenty years. He had had surgical treatment twice. His pains were severe and were attended by vomiting at least once a day. He was

sent to us by a surgeon who had heard of our experiment and was somewhat skeptical, but turned him over to us with wishes of good luck. The patient was a cadaverous-looking Scotchman who ran an upholstering business, to which he was able to attend only about two days a week, the remaining time being spent in bed. He sat through the first lecture with so glowering a countenance that it was secretly hoped he would find it convenient not to come back, but he did and went through the lecture course without missing a day. He recovered rapidly, and has never had a return of symptoms. When he had finished the lectures, his wife reported that, on returning home after the first lecture, he indulged in a burst of opinion about the lecturer that in no way indicated a profound belief in, or even respect for, the procedures. His wife, however, pointed out that nothing else had ever helped him and that he could not lose anything by giving it a try, which he finally consented to do. Initial belief would appear to be nonessential to recovery.

There is also a widespread idea that psychology can be of no value in aiding recovery from any organic disorder. The manner in which psychological training aids in peptic ulcer is fairly clear. Emotion is commonly regarded as something buzzing around in the head. The parts of the emotion that are important to peptic ulcer are the visceral stresses which attend the emotion. In emotional activity the large part of the stomach becomes flaccid, while the small part goes into strong tension or spasm and the blood supply to the stomach is greatly reduced. To obtain recovery from peptic ulcer, it is necessary that the injured tissue be replaced by scar tissue, just as in healing a cut on the hand. The healing requires rest of the part and a good blood supply, but emotion gives rise to mechanical stress and irritation, together with a poor blood supply. With the elimination of the emotional activity, rest is achieved; the destructive process is diminished or eliminated; and an adequate blood supply favors the rapid formation of scar tissue. Analyzed in terms of what is known in physiology and psychology, the processes involved in bringing about recovery become so simple and obvious as to be prosaic.

THE DELINQUENT CHILD IN PENNSYLVANIA COURTS*

BENEDICT S. ALPER
AND
GEORGE E. LODGEN
Massachusetts Child Council, Boston

THUS far the most significant developments of probation have occurred in urban centers, where density of population, with its attendant large volume of juvenile cases, has emphasized the need for adequate facilities. Sufficient attention has not been paid to the problem in rural counties. The chief result in these localities has been so to limit the forms of disposition available to the court that a disproportionate percentage of cases are committed, in comparison with the more populous areas.

One effect of this tendency is to confine in the same institution first offenders, who may never have had an opportunity for rehabilitation under supervision, and more hardened city offenders. Further, because of limitation of the forms of disposition in rural counties, the girls' cases, often baffling to the court, are sent to reform schools, without any prior attempt at reconstructive work with them in their own communities.

The purpose of the study reported here is to point out the disparities in the use of probation and of institutions for the treatment of boys and girls in urban and rural communities in Pennsylvania during the year 1932. The experience of this commonwealth may indicate to other states with essentially similar problems the need for an examination of their treatment methods.

Material for the study was secured by means of questionnaires sent to all the counties of Pennsylvania, with the excep-

*G. Richard Bacon, now of the staff of the Eastern State Penitentiary, Graterford, Pennsylvania, participated in the gathering of material for and the writing of the report from which this summary is taken. For further details see a paper by the present authors, "Survey of Juvenile Probation in 65 Counties of Pennsylvania," in the *Journal of Criminal Law and Criminology*, Vol. 26, pp. 538–55, November, 1935.

tion of Philadelphia and Allegheny (Pittsburgh) counties.[1] These questionnaires requested the following information: number of cases referred to juvenile court in 1932 for delinquency and incorrigibility, and disposition of those cases; number placed on probation, official and unofficial; number discharged; and number committed. Commitment figures were checked against a list independently compiled for that year by the Division of Research and Statistics. There was no way of verifying the validity of the figures for the other three means of disposition.

Three thousand, two hundred, and eighty-one children passed through the juvenile courts of 60 Pennsylvania counties [2] in 1932 on charges of delinquency and incorrigibility. Table 1 shows the distribution of this group by sex and class of county,[3] giving number of cases and ratio to the corresponding group in the population aged seven to sixteen.[4]

A most important fact shown by this table is that the number of juvenile delinquents relative to their proportion in the population of juvenile-court age decreases steadily as we pass from the larger to the smaller counties in the state.

[1] Because these two counties present peculiar problems, reflected in the allowances made in the juvenile-court laws of Pennsylvania, they are omitted from this study.

[2] Fifty-six counties sent in complete answers. Four sixth-class counties failed to break up the totals into boys and girls. Four counties, two sixth-class and two seventh-class, sent in no returns.

[3] Counties are classified by law on the basis of population. Class 1 (Philadelphia): over 1,500,000; Class 2 (Allegheny): 800,000–1,500,000; Class 3 (5 counties): 250,000–800,000; Class 4 (11 counties): 150,000–250,000; Class 5 (4 counties): 100,000–150,000; Class 6 (17 counties): 50,000–100,000; Class 7 (17 counties): 20,000–50,000; Class 8 (11 counties): less than 20,000.

[4] The 1930 Census figures for the age groups five to nine years and ten to fourteen years were taken as the base for these calculations. By 1932 these groups moved up to ages seven to sixteen. As the Census enumerated all ages as of April 1, 1930, and as this study was made for the period January 1 to December 31, 1932, an error has come into these calculations through the exclusion from the lower group of those who were between four and five years at the time of the Census who were nevertheless seven years old during the period covered by this study, and through the inclusion in the upper group of those who were fourteen at the time of the Census and would be, therefore, above the juvenile-court age some time after April 1, 1932. Although the precise degree in which these two factors cancel each other cannot be determined without deducting the differential death rate at each age, the error is nevertheless so insignificant as to be dismissed once it has been recognized. The delinquency rate might be slightly increased by such deduction, but the trends would remain constant.

One conclusion suggested by this steady downward trend is that the extent of minimum probation service necessary for any particular county should be determined, not only by the absolute numbers of the juvenile population, but also by the relative density and populousness of the particular unit under examination.

Comparison between the delinquent and incorrigible boys and girls on the basis of their proportions in the county population shows that, while the decrease in the percentage of boys follows in general the decrease for the whole group, the proportion of girls remains rather constant. Probation

TABLE I.—DISTRIBUTION ACCORDING TO SEX AND CLASS OF COUNTY OF JUVENILE DELINQUENTS DEALT WITH IN COURTS OF 60 PENNSYLVANIA COUNTIES, 1932

	Boys		*Girls*		*Total*	
Class of county	Number of cases	Per 10,000 of population	Number of cases	Per 10,000 of population	Number of cases	Per 10,000 of population
Third	983	55.6	183	11.0	1,166	33.2
Fourth	916	39.7	299	13.7	1,215	26.5
Fifth	194	32.7	85	15.3	279	23.7
Sixth	299	20.7	117	8.3	416	14.6
Seventh	127	18.8	56	8.7	183	13.7
Eighth	14	10.1	8	5.9	22	8.1
Total	2,533	37.6	748	11.2	3,281	23.9

service for girls and adequate study facilities could, therefore, be determined merely by the absolute numbers of girls in the population. Girls are, in the great majority of cases, brought into court for sex offenses.[1] This table suggests very strongly that there may be a certain constant percentage of the female population which, perhaps because of constitutional disposition, commit these offenses whether the environment is rural or urban. On the other hand, property crimes are by far the chief unlawful activity of boys.[2] The steady decline in the proportion of boys' cases with the decline in county population is evidence that density of population is a significant determinant of the number of offenses that boys will commit.

[1] See *Correctional Education and the Delinquent Girl*, by Mabel Agnes Elliott. Harrisburg: Department of Welfare, 1928. pp. 34–35.

[2] See *One Thousand Juvenile Delinquents*, by Sheldon and Eleanor T. Glueck. Cambridge: Harvard University Press, 1934. Table VIII, p. 100.

TABLE 2.—DISPOSITION OF CASES BETWEEN OFFICIAL PROBATION AND COMMITMENT IN RELATION TO CLASS OF COUNTY.

Class of county	*Disposition*					
	Total		Official probation		Commitment	
	Number	Per cent	Number	Per cent	Number	Per cent
Third	791	67.8	497	42.6	294	25.2
Fourth	737	60.7	407	33.5	330	27.2
Fifth	187	67.0	89	31.9	98	35.1
Sixth	271	65.1	126	30.3	145	34.9
Seventh	143	78.1	53	29.0	90	49.2
Eighth	21	95.4	9	40.9	12	54.5
Total	2,150	65.5	1,181	36.0	969	29.5

Of these 3,281 delinquent and incorrigible children, 2,533, or 77.2 per cent, were boys and 748, or 22.8 per cent, were girls. Proportionately to population, the boys far outweighed the girls. While 37.6 boys came before the court per 10,000 boys in all counties, there were only 11.2 delinquent girls per 10,000 girls.

Tables 2 and 3 show the disposition of these 3,281 cases, which were divided into two groups for the sake of clarity, Table 2 showing the relative use of official probation and commitment while Table 3 compares the two other forms of disposition—unofficial probation and discharge. The percentages are based upon the totals in the various classes of county, as given in Table 1.

Inspection of Table 2 reveals a striking fact. Excepting only eighth-class counties, the use of official probation drops

TABLE 3.—DISPOSITION OF CASES BETWEEN UNOFFICIAL PROBATION AND DISCHARGE IN RELATION TO CLASS OF COUNTY

Class of county	*Disposition*					
	Total		Unofficial probation		Discharge	
	Number	Per cent	Number	Per cent	Number	Per cent
Third	375	32.2	327	28.1	48	4.1
Fourth	478	39.3	393	32.3	85	7.0
Fifth	92	33.0	58	20.8	34	12.2
Sixth	145	34.9	90	21.7	55	13.2
Seventh	40	21.9	29	15.9	11	6.0
Eighth	1	4.6	1	4.6	..	...
Total	1,131	34.5	898	27.4	233	7.1

TABLE 4.—USE OF PROBATION FOR BOYS AND FOR GIRLS IN THE VARIOUS CLASSES OF COUNTY

Class of county	Boys		Girls		Total	
	Number	Per cent	Number	Per cent	Number	Per cent
Third	438	44.6	59	32.2	497	42.6
Fourth	340	37.1	67	22.4	407	33.5
Fifth	75	38.7	14	16.5	89	31.9
Sixth	97	32.4	29	24.8	126	30.3
Seventh	40	31.5	13	23.2	53	29.0
Eighth	5	35.7	4	50.0	9	40.9
Total	995	39.3	186	24.9	1,181	36.0

perceptibly with a decrease in county population. Use of institutions shows a counter tendency to increase steeply as we pass from more to less populous counties. The two forms of disposition are almost reciprocal. Considering only the extremes of this table, we find that where the use of probation is high, commitments are low, and vice versa. For the state as a whole, 1,181 cases, or 36.0 per cent, were placed on probation and 969, or 29.5 per cent, were committed to institutions.

Table 3 shows that the use both of unofficial probation and of discharge is more common in the larger counties than in the smaller. The use of these forms of disposition does not, however, show a continuous decrease as we pass toward the smaller counties. The third- and fourth-class counties, forward-looking in the matter of probation, seem to prefer some form of unofficial supervision over the child's case after it has been referred to the probation office. The fifth-, sixth-, and seventh-class counties tend toward the use of other forms

TABLE 5.—USE OF COMMITMENT FOR BOYS AND FOR GIRLS IN THE VARIOUS CLASSES OF COUNTY

Class of county	Boys		Girls		Total	
	Number	Per cent	Number	Per cent	Number	Per cent
Third	212	21.6	82	44.8	294	25.2
Fourth	222	24.2	108	36.1	330	27.2
Fifth	58	29.9	40	47.1	98	35.1
Sixth	96	32.1	49	41.9	145	34.9
Seventh	58	45.7	32	57.1	90	49.2
Eighth	8	57.1	4	50.0	12	54.5
Total	654	25.8	315	42.1	969	29.5

of disposition. The seventh-class counties take a stand unusual for rural counties in that they discharge few cases. As we have seen from the previous table, the eighth-class counties commit over 50 per cent of their juvenile-court cases and put 40.9 per cent on official probation. They discharge no cases whatever, and place only 4.6 per cent on unofficial probation. For all counties, the totals are 898, or 27.4 per cent of the total 3,281 cases, for unofficial probation, and 233, or 7.1 per cent, for discharge.

Comparison has been made between the various classes of county in the matter of the proportion of cases placed on official probation and those sent to institutions. Table 4 gives a comparison on the basis of the proportion of boys and of girls placed on probation.

Probation is used in a larger percentage of boys' cases than of girls'. This fact is apparent throughout Table 4, except when we come to the eighth-class counties. Table 2 showed that the use of probation for both boys and girls decreases as we go toward the less populous counties. Table 4 shows a general downward swing in the boys' cases through the seventh-class counties.

This deduction merits repetition because of its significance for our analysis: the use of probation is more highly favored for boys than it is for girls, and figures for the state as a whole bear out this discrimination. They show that 995, or 39.3 per cent, of the boys' cases and only 186, or 24.9 per cent, of the girls' were placed on official probation. The proportion is more than one and one-half to one in disfavor of the girls.

Table 5 shows the comparative use of commitment to institutions for boys and for girls.

A definite and regular upward swing in the use of commitment for boys is apparent as we pass from the third- to the eighth-class counties. An exactly opposite tendency was observed in Table 4, which dealt with the use of probation. Just as in the total figures the use of probation varied almost inversely to the use of institutions, so here we see the other side of the picture. The use of probation for boys decreases and the use of commitment increases as we pass from the larger to the smaller counties in the state.

For girls the commitment picture is almost similar. Their

commitment rate rises through the seventh-class counties, but drops at the eighth. This last class, it will be recalled, divided its dispositions of girls' cases evenly between probation and commitment. A composite table of all the girls' cases, with the exception of those in the eighth-class counties, would show, first, that the use of commitments increases quite regularly from the larger to the smaller counties, and, second, that the use of probation decreases irregularly from the larger to the smaller counties.

In brief, of the 2,533 boys' cases before the juvenile courts of 60 Pennsylvania counties in 1932, 995, or 39.3 per cent, were placed on probation and 654, or 25.8 per cent, were committed. Of the 748 girls' cases, only 186, or 24.9 per cent, were placed on probation, while 315, or 42.1 per cent, were committed.

SUMMARY

1. In 1932 the juvenile courts in 60 Pennsylvania counties heard 3,281 cases.

2. In this group of cases, boys outnumbered girls by more than three to one.

3. The proportion of children referred to the court as delinquent and incorrigible was smaller in the less populous counties.

4. The percentage of boys coming to court was lower in the less populous counties; the percentage of girls was fairly constant, regardless of class of county.

5. Probation was more common in the larger counties than in the smaller, except in those of the eighth class.

6. Commitments were more favored by small than by large counties.

7. The use of discharge and unofficial probation seemed to follow no hard-and-fast rule. In general the larger counties seemed to prefer to supervise a case informally rather than to discharge it from court jurisdiction. A somewhat contrary tendency was noted in the smaller counties.

8. According to the findings of this study, a boy who comes to court has four chances out of ten of being put on probation; a girl only two and one-half chances out of ten. Commitment rather than probation is the policy in a much larger percentage of girls' cases than of boys'.

CONFLICTS IN PERSONALITY DEVELOPMENT *

HAROLD H. ANDERSON

Iowa Child Welfare Research Station, State University of Iowa, Iowa City, Iowa

IN order to discuss conflicts in personality development, we need first to have some notion as to what we mean by personality and by development; then we can take up the problem of conflicts.

Suppose each of us tries to think of the personalities of ten persons among those we know best. What do we find? We find some who are jovial and gay, others who are shy and timid, some who meet adversity with determination and good cheer, some who break down and cry at slight rebuffs, occasional ones who get angry easily and are annoyed at the constant need for apologies, some who are always thinking of others, and others who seem unable to get their minds off themselves.

All these persons are responding to life about them. All are confronted by problems to be solved, by obstacles to be overcome, by conflicts that involve choice and action. No one has given an adequate definition of personality, but, briefly, personality is generally regarded as a mode of responding to one's environment. The mode varies with the particular momentary situation, and the tendencies toward particular modes are built out of previous contacts with or respondings to the environment.

It is necessary here to dispel some common misconceptions about the nature of this responding. The human being is often likened to a machine, a piece of mechanism which, when given fuel, performs certain actions when the proper levers are thrown. This comparison is highly unwarranted and contrary to fact. The human being is not a locomotive to be fed, oiled, and cared for in order that it may perform accord-

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ing to certain customary ways. Many adults wish that the child were such a piece of machinery and that he could be as easily cared for and controlled. Beyond a breaking-in period, the only change of which a machine is capable is to wear out. The child, however, with any given activity is not only tearing down—that is, wearing out certain body cells—but is by this selfsame process building up stronger tissues through exercise. He is not only recreating himself physically and psychologically from day to day, but is changing his goals and purposes. Unlike the locomotive, with each experience he is, so to speak, re-laying the tracks he runs on.

A child in some ways, apparently much more than an adult, is a being-in-process; he is a child-in-the-making, always varying and never the same. We hear much these days about the "whole child." We can never see the whole child or get a picture of the whole child, for by the time we get our lenses adjusted or our eyes focused, the whole child has changed.

The child-in-process who is changing within himself irrespective of his environment is also at the same time being changed by his environment. The importance of the child's relation to his environment is too often overlooked by those who have to deal with children. "Environment," as we use the word here, is a very inclusive term. By it we mean all the people, things, and circumstances which touch the child's life at any point. The parents, the family, the home, the school, the playmates, the neighborhood, the playground—all are part of the environment. Environmental influences are always affecting the mental, physical, and emotional activity of the child.

But the environment is also an environment-in-process. Not only is it undergoing a change independently of the child, but it is in turn being changed by the child. This interpenetrating of activities—an active child-in-process responding to an active environment-in-process and vice versa—is what we mean when we speak of the "whole child in the whole situation." The child is responding to an environment which is responding to the child; each is influenced and changed by the other through a succession of reciprocal responses.

It is the child's continuous and varied responding to a continuously varying environment that we call his personality.

The responding process between the individual and his environment is rendered highly complex by the phenomena of individual differences. Individual differences play an important rôle in personality development. They not only complicate the responding process of individuals, but they enrich both the process and the personalities involved. To begin with, there are differences in heredity, in nutritional status, and in energy output. As infants grow up, there are differences in the opportunities each has had for meaningful experience, in the expectations or demands their respective previous environments have made on them, and in the acquired patterns or learned techniques of responding to their environments. All these differences in heredity and experience produce differences in goals, purposes, desires, attitudes, values, or prejudices.

Other things being equal, the more personalities with whom the child comes in contact, the richer will be his own personality, for the more varied will be the patterns of his subsequent responses. This assumes that those about the child permit a variety of responses and do not stereotype his reactions by the use of fear, shame, guilt, or other forms of coercion.

The whole problem of personality development, as indeed of all education, is to make the greatest use of individual differences—that is, to secure from these differences the greatest return to the individual and to society. Healthy personality development is no leveling-off process; it is a phenomenon of growth, of learning, of enrichment, of the emergence of originals—in other words, a phenomenon of continuous or continuing creation.

Conflicts arise out of differences in human desires, goals, or purposes. Such conflicts alter personalities—that is, the patterns of response used by the individuals involved.

The nature of conflict is probably as varied and complex as the concept of personality itself. Hamlet worried over his problem of whether "to be or not to be." The indecision and vacillation of other Hamlets might be indefinitely elab-

orated and discussed. The mental conflicts revealed by Healy [1] were fundamental to the personalities of his subjects. They are, however, different from the mental conflicts of Sherman,[2] to whom any obstacle or problem in learning presents a mental conflict. It is possible that all these conflicts could be traced to differences in goals, desires, or purposes between the individuals involved and to individual differences in the interpretation of past experiences. This discussion will be confined to conflicts between individuals as, for example, between teachers and children, parents and children, or between one individual of whatever age and another individual. No attempt is made to discuss inner mental mechanisms or the manner in which choices are made.

Conflicts in desires or purposes between individuals may be real or apparent. When the conflict is real, the desires are irreconcilable; they cannot both be fulfilled. There is a real conflict between the child who wants to play with the playground apparatus whenever he happens to be ready for it and the child who is willing to take turns.

Apparent conflicts, of which there are legion in almost any home or school, arise where desires, goals, or purposes are poorly recognized or not clearly defined. Follett, in her book, *Creative Experience*,[3] has given a good illustration of an apparent conflict that was not real. According to the story, she went into a library and sat down to read a book. Having done so, she got up and opened a window. Opposite her sat another woman who said she would like to have the window closed. Were the differences real or only apparent? There are several different possible ways in which these two individuals might respond to each other in this situation. One might insist on having the window up (or down). They might spend all afternoon alternately raising and lowering the window, neither having any time to read and neither being comfortable. They might have compromised and left

[1] See *Mental Conflicts and Misconduct*, by William Healy, M.D. Boston: Little, Brown, and Company, 1917.

[2] See "How Mental Conflicts Help to Develop Children," by Mandel Sherman, M.D. In *Toward Understanding Children*. (University of Iowa Extension Bulletin, 1931, No. 261; pp. 69–77). See also Sherman's *Mental Hygiene and Education*. New York: Longmans, Green, and Company, 1934. pp. 139–166.

[3] *Creative Experience*, by M. P. Follett. New York: Longmans, Green, and Company, 1930.

the window only halfway up and halfway down. What really happened was that they talked over their desires and came to a better understanding of themselves and of each other. They both wanted to read at this table because the light was better. But one really wanted fresh air and the other wanted to be out of a draft. So they opened a window across the room, and both secured more satisfactions by having discussed their desires and purposes than they would have if they had attempted any possible adjustment of the window near the table. By reducing their desires to the lowest common denominator—that is, by arriving at a clearer statement of their respective desires—and by coming to a better understanding of each other, they found a common purpose underlying their apparent differences.

How many times are family quarrels, family bickerings, and family friction the outcome of misunderstandings, of inability or unwillingness on the part of one or more parties to attempt a redefinition of desires! How many times a teacher has been amazed at changes in herself and changes in her purposes toward a particular child when she has taken the trouble to understand him!

Let us set down as an ideal hypothesis that our aim, at home, at school, in fact in all social living, is either to discover or to create a common purpose in all cases of conflict.

If we examine in detail what happens in conflict situations, we find that when one individual confronts another, there are three possible outcomes: (1) domination, (2) compromise, and (3) integration of behavior.

The techniques of domination probably characterize a large share of human responses. Children grow up through infancy and childhood in an atmosphere highly charged with dominating forces. They respond to the world about them, discovering techniques or habits of response and adopting those found to be successful. Thus the cycle is perpetuated. All "No-No's!" and "Naughty-Naughty's!" of babyhood fall in this category. Most good-boy, bad-boy situations are efforts to dominate. Practically all slaps, spankings, and other forms of punishment are efforts at domination. All use of threats, fear, shame, blame, and appeals to authority are techniques of coercion.

What rôle has domination in personality development? For the adult who uses this technique successfully, it makes life temporarily convenient and artificially placid. It produces no growth, learning, emergence of originals, or creative experience in the adult, but it stops back talk and eliminates the need for explanation and for understanding. The goal of domination is obedience and conformity. As such, it produces conduct that is based either on a lack of understanding or on a misunderstanding, in either case having little or no meaning for the child. Obedience in itself is no virtue. It is often accompanied by fear, resentment, or rebellion, any of which may be ultimately more devastating to the child's personality than the original situation that evoked the domination.

After calling domination by all these bad psychological names, are we ever justified in insisting upon obedience or conformity? The answer is "Yes." Obedience is justified when the health or safety of the child or of another person is involved. If a two-year-old insists on crossing a busy street alone, the parent may be justified in building a fence around him. (May Heaven be merciful, however, to those parents who tether their young to a tree by a leash!) If a boy insists upon skating on thin ice, the parent may be justified in using a coercive technique if for no other reason than that the father may himself escape pneumonia.

But in all other cases the parent or teacher must establish two points: (1) that conformity has long-time as well as immediate social value and (2) that every effort has been made to understand the real or apparent difference. If before any teacher used the rod and before any parent applied the strap he had to establish this second point, the homes and schools of the land would be full of parents and teachers struggling madly to understand misunderstood children. And the next public or private whipping would be scheduled about 1940.

Domination, when successful, produces conformity or obedience. As a by-product it may produce resistance, resentment, negativism, or submission accompanied by fear, guilt, shame, inferiority, or other neurotic symptoms.

Resistance to oppression or to injustice is a form of domi-

nation, whether it expresses the rebellion of an adolescent daughter against her mother or of Gandhi against the British Empire. It is justifiable on ethical grounds as, for example, the greatest good to the greatest number. Resistance to authority may be highly commendable in the face of such cogent reasons for obedience as the conventional "because mother knows best" or "because father said so." Even here, however, resistance to authority with no yielding on the part of the parent would not be creative.

Domination is characterized by a lack of understanding or lack of intent to understand—by inflexibility. It thus maintains or increases conflict in differences, misunderstandings, opposition, negativism, or it produces conformity, obedience, standardization, stereotypes, psychological or mental vegetation.

Compromise is merely a form of less successful domination. It is a postponement of the issue. The difference, the strain, the tension are still there. In the family and the school compromise is more commonly shown in ungracious concessions. The common purpose is still lacking. Mother says grudgingly, "Yes, you may go on to the show, even thought it isn't Friday night," or, "Go on to the dance with him if you insist, but for Heaven's sake get home early!"

The third outcome when one individual confronts another is integrative behavior. In integration there is found a common purpose. Energy is expended with another, not against, as in domination and compromise. In integration there is the greatest effort to understand the motives of the other person; there is a reduction of human desires to an understandably low common denominator. Moreover, it is only in integrative behavior that we find those changes which we call growth, learning, insight, invention, emergence of originals, or creative experience.

Integrative behavior is behavior in which persons are able to find satisfactions by expending energy in a common direction or for a common purpose. It is behavior in which individuals can learn from each other, thus responding to each other, changing each other, and remaking or recreating each other through a series of reciprocal responses.

In integrative behavior the greatest attempt has been made

to understand the goals, purposes, ideals, values, and prejudices of the other and to incorporate new experience and new concepts into a unity with one's past. In order to integrate one's experience, one must yield one's present concepts for new ones that are being formed or created; one must yield one's present goals, desires, or purposes for new ones in formation as a result of the new experience.

For example, a visiting teacher (a psychiatrically trained social worker specializing in school problems) is asked to study Johnny. Johnny detests school, has found it uninteresting, and has therefore played hookey. Johnny has not been integrating very much of his school experience. The school has not been integrating very much with Johnny. In fact, neither Johnny nor the teacher see any common purpose whatsoever. So Johnny plays truant with other human beings who can show a common purpose with him, who do attempt to understand him or at least to make reasonable allowances for him. The school authorities send the boy to the visiting teacher. Johnny thinks that the visiting teacher is another conventional truant officer whose sole purpose is to get him back in school and whose technique is coercion by the use of fear, shame, threats, or authority.

It may take some time for the visiting teacher to show Johnny that it is not conformity or obedience that she is seeking, that she does not use the techniques of domination, of threats, fear, shame, or guilt. Gradually it may dawn on Johnny that she is interested in his ideas and seems to find some of them important. Only through integrative behavior—understanding Johnny, finding a common purpose with him—can she achieve that internal growth in the boy, that change which will be satisfying to him as well as to others. Domination widens the distance between human beings. Integration unites them in a common and mutually satisfying purpose. This relationship of confidence and of working together which the visiting teacher or the psychologist calls "rapport" is integration. It is creative experience. It is both the technique and the philosophy of mental hygiene. The visiting teacher seeks to understand Johnny's goals, and together they try to work out new ones that take

into account the desires or purposes of both the teacher and the parents.

Theoretically we can assume that the teacher and her pupils are working toward common purposes. Theoretically it should be possible for all members of a family to find themselves in fundamental harmony, achieving individual satisfactions through the interpenetrating activity of the family group. Practically, however, every family and every schoolroom finds its harmony disturbed by conflicts, both apparent and real.

Disturbances in the harmonious relating of experiences often arise through action in the face of apparent conflicts, hasty judgments, punishment by those in authority on the basis of inadequate understanding of the whole situation, and the imputing of intent in the face of accidents. All these forms of responding are only evidence of an inflexibility, a rigidity, an unyielding that are the very negation of all learning or growth.

There is no such thing as a "problem child." There is no such thing as a "maladjusted child." We need to abandon our use of these concepts which have placed the whole burden of adjustment on the child. We may talk of the unhappy child, the confused, bewildered, baffled child, or the child with a problem.

The child is responding to his environment, which in turn is responding to him. He was not born with these patterns of responding; he has been learning them from somebody else. Dealing with the problems of children requires a philosophy different from that of the traditional home and of the traditional schoolroom. In addition it takes a training that can understand the stresses and strains of a myriad of factors as they push and pull at the growing, changing, learning child.

DIRECTED EXTRA-CURRICULAR ACTIVITIES AND ADJUSTMENT

FRED G. LIVINGOOD, ED.D.
Washington College, Chestertown, Maryland

THREE terms in the title of this discussion need definition—"extra-curricular activities," "directed," and "adjustment." "Extra-curricular activities" may be defined as those legitimate activities which have been developed in schools to supplement the curricular program, with a view to realizing more completely the aims and functions of education. Many activities that in earlier days were considered as extra-curricular have to-day attained curriculum status. In the opinion of some educators, these activities are in direct conflict with those in the academic field, but on the whole authorities are agreed that they have enriched the school offering and have given to the school renewed vitality in providing curriculum laboratories. The term "directed" can be interpreted as sympathetic guidance in contrast to absolute faculty-administrative dictation, domination, and control. "Adjustment" refers to the quality of a person's behavior in terms of social effectiveness; hence the adjusted student is free from excessively disturbing inner conflicts which hinder his effectiveness as a campus citizen and which interfere with his health and happiness.[1] While this discussion is primarily concerned with the small-college group, the principles are fundamentally the same for other levels of education.

Directed extra-curricular activities as an aid to student adjustment have been too frequently overlooked in schools and colleges. Too often campus activities have lacked direction, with the result that they have come to be regarded as unnecessary appendages of college life or as an end in themselves, too little consideration being given to the idea that they might be made the means to an end. Where extra-cur-

[1] See *Mental Health*, by F. E. Howard and F. L. Patry, M.D. New York: Harper and Brothers, 1935. p. 19.

ricular activities have been an end in themselves, they have become a stumblingblock in the path of education, to say nothing of the bad effects that such point of view has had on institutional as well as on individual student problems. Critics of extra-curricular activities point out instances in which public and private schools, as well as colleges, have become ridden by such activities, with unfortunate results in the way of a break-down of the morale of the institution, a weakening of the educational fiber, the creation of many individual student behavior problems, and in general no end of trouble. The difficulty in the past has not been that the extra-curricular activities were not worth while, but rather that they were not interrelated with the entire structure of education and student adjustment.

The average youth who leaves home to attend a preparatory school or college is confronted with numerous problems of adjustment. In the first place, the transfer from home to campus-dormitory life creates perplexities. In contrast to his earlier experiences at home and in school, where life was reasonably well organized for him, the youth finds himself in a new environment with numerous adjustments to be made, including the allotment of hours of work and recreation, the choice of companions, the selection of academic courses, the demands of social groups, and he comes to realize that the problems of adjustment outside of the classroom and laboratory bulk large, not only because of excessive demands on time and effort, but also because of important decisions to be made.

In the second place, the transfer from one level of education to another, or from one institution to another, gives rise to additional problems. Too seldom does youth realize that education is a selective process and that as he advances educationally, competition of all kinds becomes increasingly keener. Whereas he was an "A" student in the home-town school, he now finds that he must be content with a "B" or a "C" grade for the same amount of effort, or he must put forth more effort and develop systematized working habits if he expects to maintain his former academic rating. He finds this true not only in regard to the curriculum, but also in the extra-curricular field. When he was a leader in the secondary

school from which he came, taking an active part in athletics, dramatics, music, and literary clubs, he now finds keener competition in these fields. With the demands of both classroom and campus activities increasing, choices must be made. In too many instances, rather than allow his social prestige to wane, the student neglects his class work, with consequent effects on his academic standing.

The failure of a student to make adjustments is not the failure of the student alone; it becomes the failure of the college also. It should be the purpose of an educational institution to organize the entire situation so that there is a favorable opportunity for both teachers and students to practice the qualities of good citizenship with results that will be satisfying. In the final analysis, the effectiveness of an educational institution cannot be measured alone in terms of success in imparting knowledge; it must be measured also in terms of its effects upon the health of mind and body of the student.[1] To limit direction and guidance to a few fields, such as the academic and the vocational, limits the effectiveness of the institution. If extra-curricular activities are to be regarded as those activities which are student-conducted, student-directed, and maintained without faculty guidance, then it is easy to understand how over-participation and over-emphasis have made extra-curricular activities objectionable. Needless to say the institution that does not maintain some supervision over campus activities will be student-activity-ridden, and as time passes it will become increasingly difficult to determine which group controls the school—the students or the administration. On the other hand, there is the possibility of such domination and restriction of extra-curricular activities that the policy defeats its own ends. The real difficulty is generally due to the lack in both student and faculty groups of any real understanding of extra-curricular activities. There is a middle ground of intelligent direction of such activities based on a real comprehension of their value as a vital force on the campus—not only as a means of recognition of the social impulses and the desire to achieve, but also as a method of assisting students to become well-rounded and well-adjusted campus citizens. Possibly the term "extra-

[1] Howard and Patry, *op. cit.*, p. 187.

curricular'' should be discarded and the term ''campus activities'' used to include all activities, classroom and out-of-class activities, looking toward an integrated campus program. After all, it is reasonable to assume that integrated personalities are more likely to develop on a campus on which an integrated program of all activities is in force.

Colleges find it necessary to make rulings affecting the amount of academic work that students may carry with profit to themselves; hence advisers allot student class loads on the basis of capacity and on the basis of attainment. Furthermore, each student must carry a minimum class program if he is to continue in college. In like manner some secondary schools and colleges have set up a point system designed to restrict extra-curricular participation and to limit the number of major offices that any one student may hold. In too few instances is there any regulation insisting that every student shall participate in some extra-curricular activities as a part of his student load. If a student fails in his academic work, either by reason of a work load beyond his capacity or because of his failure to work up to capacity, he is usually invited to the dean's office. Is it not reasonable to assume that advice and guidance should be given to the student who is not actively participating in, or who is doing poor work by reason of over-participation in, extra-curricular activities? It would seem that the problems of extra-curricular adjustment and academic adjustment must be considered as interrelated if the best interests of the student are to be realized.

College students in relation to extra-curricular activities fall into three classes: the upper 10 per cent, the middle 75 per cent, and the lower 15 per cent. The first are those who by reason of leadership and versatility are called upon to lead or to participate in an excessive number of activities. The second, the middle 75 per cent of any student group, are those who find their place in campus life with little guidance or who take the course of least resistance, participating in activities that are the vogue on the particular campus on which they find themselves. The third is made up of those students who, by reason of personality, diffidence, or the un-

fortunate play of circumstances, participate in few or no activities.

The first group of students, possessing leadership ability and considerable versatility, are able to make some sort of adjustment regardless what the situation may be. They are generally outstanding students, and even though extra-curricular activities demand an inordinate amount of time, they are able to keep up with the average class group. Once they get into scholastic difficulties, particularly if they are the holders of scholarships, the extra-curricular problem becomes a difficulty for them, since they are quick to realize the problem, but sometimes hesitant to resolve it by reducing extra-curricular participation in the face of student opinion. For this group direction and guidance is essential. These men and women in the upper 10 per cent are usually the students who in their junior and senior years become the heads and guiding spirits of most campus activities. As a rule they are individuals of superior talent, possessed of real insight in guiding student opinion and student action along constructive lines, and by reason of their multitudinous campus contacts they are able to coördinate campus activities, after a fashion, for busy administrators. Too often a college administration is willing to overlook point-system enforcement in order that the majority of campus activities may be headed by two or three individuals of unusual leadership ability, the apparent oversight being generally excused on the plea that this was the procedure followed in the past, notwithstanding the fact that many of these individuals would have left college better integrated had they not had excessive burdens of student-activity administration. There is no need to encourage this group to participate in activities. The problem is rather one of guiding them and restricting over-participation according to their abilities, accomplishments, aptitudes, and interests. This is particularly a problem of the small college rather than that of the large college or university because of the proportionately larger number of campus activities and the smaller number of student leaders, not because of a smaller ratio of outstanding students.

The student of the upper 10 per cent too often gets into difficulties as a result of poor budgeting of time and activities,

poor management of the capacity for alternative choice and decision, and as a result of an attempt to participate in too many experiences, finds himself approaching the status of a disorganized personality. Because of the demands of classroom and campus activities, the student may fail in both and satisfy neither instructors nor fellow students. Feeling the slight to social prestige, were he to give up the extra-curricular activities, more than that to academic prestige, he may try to find a solution of the problem in the development of academic standards and mental attitudes conducive to mediocrity in both curricular and extra-curricular fields.

The following case illustrates the problem of a student in this group of the upper 10 per cent:

> Student A in his freshman year was marked as a student with outstanding leadership ability, scholastic aptitude, and talent. The appeal of the various student organizations was flattering to him, with the result that he affiliated with six or eight activities. Needless to say the fraternity groups were not ignorant of his presence on the campus. During the first two years of campus life, the time and attention demanded of him for campus activities began to mount, depriving him of time for academic work. With new offices and new responsibilities in the junior year, A's scholastic deficiencies reached an all-time low, with the result that he was invited to the dean's office for consultation. Excessive work, curricular and extra-curricular, became a source of worry to him, with the result that his effectiveness in both lines of activity declined. He became less dependable, developed moody states, and finally came to the realization that he was at the cross roads where a decision was imperative lest he completely ruin his college career.
>
> After consultation with an adviser, A decided to limit his activities to those that would be of the greatest value to him for the remainder of his college career and in the light of his plans after college. With his program definitely charted, he completed his college course, leaving behind him a record as an outstanding student and an outstanding campus leader.

The second group of students consists of the middle three-quarters of the student body, students who generally are not outstanding either by reason of scholastic aptitude or scholastic accomplishments. In many instances potentialties for leadership are present in this group, but the individuals are quite willing to allow their talents to remain hidden. Like the general average of any group, these students make up the general membership of student organizations. While many have special talent, they are generally satisfied to follow student opinion and to participate in those activities that

have the greatest campus following, whether those activities are appealing to them or not. Because of lack of interest, they become indifferent followers. There are always some few in this middle group who attempt to carry activity participation in excess of scholastic ability, with the result that they are frequently in difficulty. As a whole the middle group are quite satisfied to leave leadership to the few "campus gods," while they blindly follow campus dictates. Adjustment for this group on a trial-and-error basis leaves a majority of them better adjusted in relation to campus life than either the upper 10 per cent or the lower 15 per cent.

Of the three groups, the lower 15 per cent of the student body is the group in which guided and encouraged extra-curricular participation is likely to yield the greatest values to individuals in the way of helping them to attain social and mental adjustment. The upper 10 per cent of a campus-activity group are relatively homogeneous, with possibly some few exceptions, in leadership ability and in widespread participation. However, as we come down through the succeeding deciles of any student group, we find it becoming increasingly diversified. In the lowest group will be found all gradations of scholastic ability, scholastic accomplishment, and talent. These individuals, by reason of earlier training, environmental influences, physical condition, lack of specialized abilities, or over-specialization in some field, have never become satisfactorily adjusted and, unless guidance is provided, they leave college little improved over what they were when they entered. It is from this group that many problem individuals are being recruited for society. A check on classes out of college ten years will confirm this statement. The individuals in this group need encouragement, training, and direction in participation in campus activities. The opportunity for directed participation for an individual student often brings to light hidden talents, develops unsuspected leadership capacities, and may be the means of developing worth-while compensations in certain fields to make up for deficiencies in others. Without direction and guidance, a college campus is likely to have a "submerged tenth" who take little or no part in campus activities and whose education is restricted to the classroom and to incidental campus contacts. Here are to be

found the students with pronounced tendencies of withdrawal from the group because of fancied inferiorities, to whom directed extra-curricular activities can render its greatest service. Several cases of students from this group are cited here:

Student B entered college several years younger than his classmates. His age, coupled with his lack of physical development, made him the target of a great deal of good-natured teasing. In as much as he was taken by his college mates into their circle, the bantering did not particularly annoy him, since there was the compensating factor of being noticed by his fellows. As time passed, B developed a sense of deficiency which became noticeable in more pronounced stammering during the first two college years. In his junior year, because of the withdrawal of the president of the class, B's classmates elected him president. This B regarded as more "kidding," taking his election as in the nature of a joke. The more he considered his new honor, the more worried he grew; and when he thought of appearing before the class to conduct class meetings, he became so upset that he was unable to sleep, became indifferent in his academic work, neglected his self-supporting college duties, and finally in desperation turned to an adviser. After numerous conferences and the advice that he participate in literary-society work and debating, B developed sufficient poise to conduct class meetings to his own satisfaction and to the surprise of his classmates. In his senior year he became a member of the intercollegiate debating team and on commencement day received a medal as one of the two men who had achieved most in debating.

Student C as a freshman was a very retiring type of individual, rarely appearing on the campus except to attend classes. At the end of the freshman year, he was urged to try out for the position of pianist in the college orchestra, but he felt unequal to the task. After some persuasion C suffered a change of mind the next fall and hesitatingly agreed to serve. With the position of orchestra pianist came the opportunity of playing for college affairs, thus placing C in the college limelight. Along with greater confidence in himself came independence in thought and action. Whereas C had been the type of individual who is rather plastic in the hands of others, he now began to map out his own program. Dating from his participation in the college orchestra, there developed in him a sense of self-confidence and self-reliance. The retiring freshman became the confident upper-classman who to-day is a member of a profession that requires self-confidence, decision, and the ability to influence others. Extra-curricular activities made a real contribution to C's education.

To plan a program for the effective organization and administration of directed extra-curricular activities is an easier matter than to insure that the program will be effectively carried out. In the final analysis, no designed program and no group of selected extra-curricular activities will necessarily meet the needs of any given school or college.

Both the plan and the activities chosen must grow out of the needs of the particular institution and the particular group of students. Conditions may vary from year to year, requiring a different organization, changed procedures in administration, the discarding of some activities, and the addition of others. The following plan is merely suggestive of a scheme of organization and administration that would insure a more effective program for directed extra-curricular activities:

A. Personnel:
   1. A faculty director of extra-curricular activities, preferably a faculty-student liaison officer.
   2. A sympathetic faculty committee consisting of
      a. The faculty director of extra-curricular activities.
      b. Faculty sponsors of selected activities.
      c. The college psychiatrist and the college physician.

B. Methods of discovering student extra-curricular interests:
   1. Entrance requirements to include a letter from the student, following a suggested outline, indicating hobbies, interests, and secondary-school experiences.
   2. A statement from the principal or a selected teacher of the preparatory school, indicating the student's hobbies, interests, and attainments.
   3. Conferences with the student.

C. Other essential features:
   1. An extra-curricular-activities point system, based on scholastic aptitude, scholastic attainments, and demonstrated extra-curricular abilities.
   2. Extra-curricular-activities points required for graduation, thus insuring the participation of all students.
   3. Close relation to all other forms of guidance.
   4. Complete central files available to officers of the administration, psychiatrist, physician, director of extra-curricular activities, and faculty sponsors, with complete information concerning all records by semesters, including curricular, extra-curricular, physical, and psychiatric recommendations.

What, then, are the contributions of directed extra-curricular activities to student adjustment? First, directed activities will reduce or prevent the mental conflicts and attending difficulties that result from over-participation both on the part of the upper 10 per cent of the student body who carry excessive activity loads and on the part of the lower deciles of students who attempt to carry extra-curricular responsibilities not in keeping either with their capacities or their past attainments. Second, by relieving the upper 10 per cent of the student body of the burden of providing total

campus leadership, a directed program will offer opportunities with guidance for other capable students who may thus have the satisfaction of achievement plus the privilege of leadership training. Third, a directed program will provide stimulation for the students of the lower deciles, and particularly for the lower 15 per cent of the student body, discovering hidden talents and aptitudes that will give satisfaction to the participant, to say nothing of the vital contribution to both social and mental adjustment. Finally, such a program will relate more closely all of the varied phases of campus life, curricular and extra-curricular, student activities and faculty activities, thus providing for a more integrated campus life, enriched campus citizenship, and better adjusted personalities.

UNGUARDED DISCUSSIONS AT THE BEDSIDE

E. Y. WILLIAMS, M.D.
Instructor in Neurology and Psychiatry,
Howard University, Washington, D. C.

DISCUSSION at the bedside of a patient as to the nature of his illness when such discussion is guarded has been found to have little or no ill effect upon the course of the illness. On the contrary, the assurance and hope given have at times been most beneficial. But too often this factor of the patient's reaction to a discussion of his condition is overlooked, both in the home, where a series of questions are frequently put to the doctor at the bedside, and in the hospital, where the curiosity of the staff as to the relative value of the findings is expressed in the presence of the patient. Whether in the home or the hospital, if the patient is not too ill, he is always a curious listener, and upon the words of the doctor quite often depend the extent or speed of recovery.

In order to determine the effect of unguarded discussion upon the patient, 80 cases were taken at random from three separate groups as follows: (1) 55 from our hospital wards; (2) 22 from the out-patient service; and (3) three seen in the home.

In 62 of these 80 cases, a statement as to the nature of the illness was overheard by the patient. Fortunately only 39 understood to any degree what was said, or else realized definitely what was wrong. In most of these instances, the patient had been informed by the family physician before entering the hospital, and thus realized that only further treatment in the hospital could be of aid in recovery. Eight of the 39 were not affected one way or another by what they had heard, five feeling that they would ultimately get better, with no assurances one way or the other, while three felt that they were being punished for their wickedness and, once punished enough, would recover.

Of the 31 patients who seemed to have been affected by what

they had heard or who misunderstood the nature of the illness after the whole matter was explained, 22 felt assured and looked forward to recovery. In nine cases, the element of doubt was not so easily removed. These individuals felt in part either that the doctor was merely trying to reassure them or that some unknown possibility better understood by the patient was lurking in the background. In all nine cases, neurotic trends were markedly exaggerated.

Fear reaction was marked in the 31 cases, and of so serious a nature in six that it required more than assurance for recovery. The chief offender in most instances was the family, who either were unable to interpret the doctor's statements or who looked with gloomy foreboding on the illness.

Though the number of cases is not large enough to have much statistical significance, a relationship between the source of the information and the patient's reaction to it is indicated by the following figures:

Of the 62 cases, 38 were informed by the doctor, 29 directly and 9 indirectly, with a resulting depression in 13 cases and of deep depression in 4.

Nine cases were informed by the family, 3 directly and 6 indirectly, with a resulting depression in 6 cases and of deep depression in 2.

In the remaining 15 cases, the information came from both doctor and family, in 12 cases directly and in 3 indirectly, resulting in depression in 12 cases and in deep depression in 3.

These figures would seem to indicate that information given by the family brought forth a deleterious reaction in a greater proportion of cases than information given by the doctor, and that when doctor and family both informed the patient, the proportion of those who reacted with depression was still greater.

On the other hand, the family, perhaps because of closer contact, had a slightly better record in the matter of the number left depressed. The family seemingly had better results in so far as keeping the patient cheerful and reassuring him. In many instances, however, this was due to the reassurance the doctor gave to the family.

The factor of emotional reaction of individuals in relation to the food taken was also considered. Cannon has demon-

strated the effects of rage, fear, pain, on digestion,[1] and Newton, Cannon, and Zwelmer[2] have shown how emotion may even accelerate the denervated heart. Silvette and Britton have demonstrated[3] the comparative reaction of carbohydrate metabolism in emotional and non-emotional states, proving the influence of emotional states upon bodily activity.

In 13 of our 62 cases, appetite was not affected even for a meal, though the patients admitted that they did give some thought to their illness while eating. In the other 49, the period during which appetite was affected ranged from one meal in 11 cases to five days in one case and six days in another. In most cases it was two days.

The histories that follow illustrate the reactions of various types of patient to remarks overheard by the patient concerning the nature of his illness.

Case 1.—R. L., a preacher, fifty-five years of age, came to the hospital suffering from an attack of cardiorenal disease. He had had such attacks repeatedly, had always recovered from them, and felt that this would be no different from the others. But overhearing a statement of the doctor's that he had a "split second sound," he interpreted it to mean a split heart. If, he reasoned, he had a split heart, then it could only be a matter of time. Moreover he heard a student remark after listening that the prognosis was poor. This word *prognosis* he got only in part, calling it "pronouncit." That evening he called his family, explained to them where his will was, and resigned himself to his fate. He was taken to a clinic for psychiatric demonstration, where he expressed his fatalistic views of his case. The effort to change his interpretation of what he had heard was of no avail as he had explicit faith in the men who had examined him. He died that evening after the clinic.

Case 2.—R. S., a patient of thirty-five, was told by his physician that he had tuberculosis and that it would be only a matter of months before he would die. Believing this to be true and unable to leave the city, he took a hopeless view of the situation and began drinking. On some days

[1] *Bodily Changes in Pain, Hunger, Fear, and Rage*, by W. B. Cannon. New York: D. Appleton and Company, 1918. pp. 1–21.

[2] "Mystery of Emotional Acceleration of the Denervated Heart After Exclusion of Known Humoral Accelerators," by H. F. Newton, R. L. Zwelmer, and W. B. Cannon. *American Journal of Physiology*, Vol. 96, pp. 377–91, February, 1931.

[3] "Comparative Effects on Carbohydrate Metabolism of Exhausting Motive and Emotive Responses and Exposure to Cold," by H. Silvette and S. W. Britton. *American Journal of Physiology*, Vol. 100, pp. 685–92, May, 1932.

he would go to the park, drink enough to get intoxicated, and stay in the sunlight (to which might be attributed his partial recovery), remaining there for hours. Months passed and he showed no signs of growing worse. In fact, he believed that he was getting better. He had spent a great deal of his money by this time and was forced to go back to work. As a bellhop working nights, he soon felt that he was not as well as he should be and gave up the job. He took a job at a gasoline-filling station and while he does not feel that he has wholly recovered, he states that it has been "years" since he was told he would die.

Case 3.—A woman of thirty-eight years, who felt a desire to be in the company of doctors and who at one time thought that she would be the wife of one, became ill with what she believed was a stroke after a fall. No doctors in her part of the country that she called in were able to understand her malady and she was advised to go to Philadelphia. There she overheard the doctors in the hospital to which she was confined discussing her case, which enabled her to add a few new symptoms to her illness. She was told that nothing was wrong with her and left the hospital in disgust, going to a Baltimore hospital. The same opinion was advanced there, but not before she had again overheard some discussion of her case.

Her hemiplegia had many of the features of an upper motor neurone lesion, save for the Babinski and lack of < reflexes. Spasticity was increased, or seemed to be, on that particular side, and there was a diminution of all sensory impulses on that side save over the area of the heart, a most significant omission, based on the fact that she believed that since she was alive and her heart was on the left, it would be bad policy to have a heart beating and yet paralyzed. She was pronounced a case of hysteria and treated as such, with recovery. Her many symptoms were largely due to suggestions she had overheard.

Case 4.—A. L., a woman of twenty-eight, appeared at the out-patient clinic for treatment. It was known that she had a positive Wassermann. She overheard three students discussing a case like hers and the treatment of it, and became interested. When called in for examination, she put a hypothetical case before the examiner, asking his opinion. Not realizing the source of her information, he corrected her and told her what the results would be. Whereupon she remarked, to the astonishment of the examiner, "Then I won't be cured for two years or more." He found it impossible to say yes or no, as he had not investigated her case. She was consoled, however, by the statement that he had referred to the danger of transmission, not to the disease itself. The social significance of the disease was explained to her and she seemed satisfied.

Case 5.—G. A., a man of sixty-six years, was told by his physician that he had high blood pressure and that he would live only a few months. He rested quietly waiting for the few months to pass, in the meantime discharging the doctor. Instead of dying, the patient recovered, and went back to his job of poultry-raising, and lived five years longer. In these last years, his confidence in physicians was greatly shaken, as he pointed to his increased vigor, never for a moment

feeling that it was due to the fear of death which had kept him in bed and therefore been a great factor in his recovery. His death occurred later suddenly and peacefully in his sleep.

Case 6.—C. L., a young woman of twenty-one, came to the hospital with fainting spells, pain under the right breast, and pain in the chest. She gave a history of an abscess at the tip of the sacrum, which exuded some pus on pressure when she was admitted to th ,hospital. Subsequent examinations proved negative for any lesions whatever. She overheard the doctors saying that nothing was wrong with her and this apparently caused her great emotional upset and anguish, as she had given up her job because of her illness, feeling that she had a tubercular spine. A diagnosis of anxiety neurosis was subsequently made, her symptoms were explained, and eventually she left the hospital improved.

Case 7.—G. A., a patient of fifty-five, came to the clinic complaining of pain in the calves of his legs. His request was that no attempts be made to take his blood pressure or to tell him that he had arthritis. This, he explained, was due to the fact that he had been to three hospitals before, and at times a crowd of young doctors would come around him, take his blood pressure, listen to his heart, and then discuss how sick a man he was and what would be the outcome of his illness. These remarks infuriated him. More recently he had been told that he had arthritis and had been treated for that, with no effect. Examination revealed that the patient had a slight increase in pressure——155/115—but in addition suffered from multiple neuritis. The calves of the legs were rather painful on firm pressure. Sensitivity to pin prick, heat, and cold was diminished. Position sense was present, but vibratory sense was markedly diminished. The ankle jerk was absent and the knee jerk diminished. A further investigation revealed marked deficiency in the patient's diet, this consisting largely of crullers and coffee in the morning, sandwiches and cake at noon, and what he termed a good dinner in the evening. He was treated for neuritis and referred to the dieticians, and has shown some slow improvement. He seems satisfied with his new régime.

Case 8.—R. C., a young woman of thirty, upon whom a diagnosis of multiple sclerosis was made, overheard the doctors saying that she would never recover. She cried for nearly two weeks after that, becoming almost hysterical at times. She was given some reassurance, and in the meantime, a remission came and some hope or confidence was restored. She has had another attack since and has again begun to feel that what she overheard was correct. Reassurance on the second occasion was rather a difficult task.

These cases, I believe further prove the necessity of including psychiatric teachings in the instruction given on the general wards of the hospital, for only in this way can the total personality of the patient, and its influence in disease as well as in health, be appreciated.

CONCLUSION

1. Bedside discussion should at all times be guarded whether the patient be of a neurotic temperament or otherwise.

2. Attempts should be made to help the patient to concentrate less on self in disease.

3. Psychiatric study should form a definite part of the routine history on every case in the general hospital.

THE SOUTH DAKOTA MENTAL SURVEY AS A BASIS FOR SOCIAL CONTROL OF THE MENTALLY DEFECTIVE

J. H. CRAFT

Psychologist, South Dakota Commission for the Control of the Feebleminded

A STATE-WIDE survey of the mentally defective was begun in South Dakota in 1925 for the purposes of identifying the mentally defective and making a study of the social problems that are caused by their presence in the community. This survey was instituted by legislative enactment at the instance of Dr. F. V. Willhite and placed under the direction of a commission to be known as the State Commission for the Control of the Feebleminded. This commission was charged with the duty of conducting the survey and devising a program for the social control of the mentally defective who are at large in the state.

The state commission is composed of three members appointed by the governor for a term of five years. The law specifies that the superintendent of the institution for the feebleminded is to be ex-officio chairman of the commission; a second member is to be a lawyer, and the third a physician. Compensation is on a per-diem basis, including actual expenses for the time spent in service on the commission. The first commission included Dr. F. V. Willhite, chairman, Hon. Lewis Larson, and Dr. G. S. Adams. These members were reappointed and have served on the commission throughout the ten-year period of this report.

The state commission appointed two psychologists and later a third to carry on the mental survey. The expenses of the survey were covered by a special appropriation for the first two-year period, after which it was provided that they be paid out of the budget of the state institution for the feebleminded.

The mental survey has proved to be the foundation for a program of social control of the mentally defective in South Dakota. As soon as the survey began to reveal the extent of

mental defect in the state, a program of control was developed by the state commission, whose powers were extended by new legislation. The state legislature has always been ready to pass the necessary legislation when the findings of the survey were presented and the needs were made apparent.

The program for the social control of the mentally defective that evolved during the period of this study includes the following phases: (1) Identification, (2) Classification, (3) Registration, (4) Segregation, (5) Education, (6) Sterilization, (7) Prevention of marriage, and (8) Supervision. The present report deals with the first three phases of the program. The other phases will be studied and reported in later articles.

Identification of Mental Defectives.—One of the first practical problems that confronted the psychologists at the beginning of the survey was that of finding the mental defectives. As is customary in such surveys, they turned to the schools, the institutions, the public-health centers, the welfare agencies, civic officials, clergymen, physicians, and others whose contacts enabled them to point out mental defectives and furnish information about them.

For laymen, there are two important means of identifying individuals as mentally defective. One is serious retardation in school and the other is abnormal behavior. Information concerning the first is obtained from the school records, and concerning the second from the subject's associates and other persons who are familiar with his behavior and any outstanding defects that he may have. The main source for locating the mentally defective in this survey was the records and information made available through the schools, including teachers' periodic reports, the school census, the questionnaire, group-intelligence tests, achievement tests, and grade-progress records. The use of age-grade records, achievement, and group-intelligence-test ratings in the selection of mentally retarded children for investigation and examination is obvious. The questionnaire makes available a direct report of the child's ability by the teacher. This report, which is required by law, gives the age, the grade, and the grade ability of each seriously retarded child. Other mentally defective children and adults in the district are also reported by the teachers. Estimates of grade ability are not always

made, but those that were have, in most instances, proved to be very reliable. A random sampling of 210 of these reports of grade ability and mental age give a coefficient of correlation of .86±.01.

In the rural schools the psychologist has to depend mainly upon the school-progress records and the teacher's judgment for the selection of children for testing. Each county is surveyed as a unit. First, the record of each child is examined and an individual report from the teacher is studied. To avoid the necessity of visiting every school, the psychologist attends the county institute and goes over the records with each teacher. A more accurate method of selection would be by means of group intelligence tests administered to all school children, but with a limited staff and budget this method is out of the question. All town and city schools are visited, and group mental tests which aid in the selection of cases are often given in schools that do not have their own testing programs.

The teacher is asked, not to state the retarded child's mental age, but to estimate his grade ability. The psychologist translates this grade ability into mental age, which is expressed in terms of the intelligence quotient, showing its relationship to chronological age. In order to allow for errors of estimate, most of the children who appear to be of borderline intelligence are also examined. In fact, the registry shows that for each child with an I.Q. below 70 examined, there are four with I.Q.'s in the 70's. There are, of course, some with I.Q.'s above 80, due to errors in selection.

Backward children are usually identified in the school. Idiots and most imbeciles do not attend school, but may be found on the school census. The teacher reports most of them on her questionnaire. Those cases found in the various institutions are examined and registered for the county of their legal residence, as most of them are discharged from the institution at some time.

The more outstanding adult defectives are identified through the same sources as the children. Obviously it is difficult for a psychologist to find the high-grade moron at large in the population, so that not many outside the institutions are classified. Those found are generally identified through the facilities of the social agencies, the larger ones

always selecting a number of defectives among their clients, for whom examinations are arranged.

Methods and Results of Classification.—Two methods of classification are used in the South Dakota mental survey—the individual-test method and the case-history method. In all 5,762 defective persons have been classified. The intelligence quotient is the determining factor in making the preliminary classification, upon which most of the statistical reports given in this article are based. A final and legal classification is based upon a retest by the psychologist and a case-history report by the physician, who is a member of the subcommission for the Control of the Feebleminded. This case history gives the subject's developmental history, physical defects, disease history, familial history of nervous and mental diseases, and the results of mental tests of siblings and other relatives. A report of the economic adequacy and the school record of the subject are also a part of the findings that influence this final classification. The following tests are used in determining the preliminary classifications: the Stanford revision of the Binet-Simon scale (Stanford-Binet), the Kuhlmann revision of the Binet-Simon scale (Kuhlmann-Binet), the Pintner-Paterson performance scale, and the Hayes adaptation of the Stanford revision of the Binet-Simon scale (Hayes-Binet). The Stanford-Binet and the Kuhlmann-Binet have a more general use. Individuals who have some special handicap require tests adapted to their condition. The non-verbal scale of the Kuhlmann-Binet is used for children with a language handicap; the performance scale is used for the deaf and the illiterate, for Indians, and for foreigners; the Hayes-Binet is used for the blind; the Kuhlmann-Anderson intelligence test is used as an individual test in a few instances in which the subject is able to do better in a written test. During the first surveys, the national intelligence test was administered and later the Kuhlmann-Anderson test was used for selecting subjects at the boys' and girls' reformatory. All prisoners and youths at the reformatory who made I.Q. ratings below 80 were reëxamined with an individual test and the classification was based on the results of this test.

The classification of intelligence according to the intelligence quotient as determined by means of these various tests is as follows:

Classification	*Stanford-Binet Hayes-Binet Pintner-Paterson* I.Q.	*Kuhlmann-Binet Kuhlmann-Anderson* I.Q.
Idiot	0–24	0–24
Imbecile	25–49	25–49
Moron	50–69	50–74
Border line	70–79	75–84
Dull	80–89	85–94
Average	90–109	95–104
Bright	110–129	105–124
Superior	130–149	125–149
Precocious	150–	175–

The mentally defective are classified as idiot, imbecile, and moron according to these ratings.

During the period of this study, 12,052 individual first examinations were made by the state commission. Several thousand group intelligence tests were given, but the results have not been tabulated, except those of certain institutional groups.

A summary of the mental defectives classified in the survey is given in Table 1. This table shows that a total of 5,762 mental defectives have been classified; that is, .85 per cent of the general population was found to be mentally defective. Of this group of 5,762 defectives, 329, or 6 per cent, were idiots; 1,131, or 19 per cent, were imbeciles; and 4,302, or 75 per cent, were morons. There were 3,455 males and 2,307 females, making the ratio between the sexes 3 to 2.

The variations in the incidence of mental defects in the 64 counties of the state are brought out in Table 2. This table shows that the percentage of defectives per county varies from .4 per cent (calculated to nearest tenth per cent) to 1.9

TABLE 1.—SEX AND INTELLIGENCE LEVEL OF 5,762 MENTAL DEFECTIVES EXAMINED IN THE SOUTH DAKOTA MENTAL SURVEY, JULY 1, 1925, TO JUNE 30, 1935

	Total defectives *	*Idiots*	*Imbeciles*	*Morons*
Male	3,455	182	626	2,647
Female	2,307	147	505	1,655
Total	5,762	329	1,131	4,302

* According to the South Dakota State Census Report of 1935, the total state population was 675,082, of which 351,163 were males and 323,919 females.

per cent—a range of 1.5. The mean is .87 per cent and the standard deviation is .30.

As already indicated, most of the examinations were made among children of school age. The distribution of cases showing the age at which the examination was given is shown in Table 3. The largest number of examinations were given to children of from ten to fourteen years of age. Up to ten

TABLE 2.—DISTRIBUTION OF MENTAL DEFECTIVES IN THE SIXTY-FOUR SOUTH DAKOTA COUNTIES AS CLASSIFIED IN THE MENTAL SURVEY, 1925–1935

Percentage of mental defectives	*Number of counties*
1.9	1
1.8	1
1.7	1
1.6	0
1.5	0
1.4	0
1.3	3
1.2	4
1.1	4
1.0	9
.9	4
.8	13
.7	8
.6	10
.5	4
.4	2
	64
Mean	.87
Standard deviation	.30

the psychologists are inclined to give the child the benefit of the doubt, though the outstanding cases of subnormality are examined before ten. After that age, the number of children examined tends to increase for each year of age because of the increasing amount of retardation, with a dropping off at seventeen, which is the upper age limit of compulsory school attendance. Each county is surveyed every two years. Care is taken to examine all mental defectives some time during their school life—that is, between the ages of six and seventeen. Most of the classifications of children below six, which are made outside of the institution, are for idiots and

imbeciles. There is also a predominance of low-grade defectives among the adults that have been classified.

The special types of mental defective always attract the attention of laymen. Most individuals of these types who are above five years of age have evidently been identified, as they do not appear in resurveys. Many of the children of pre-school age are identified because of their physical anomalies. Table 4 gives the distributions of the special types of mental defective. This table shows that of the 5,762 mental

TABLE 3.—AGE AT TIME OF EXAMINATION AND INTELLIGENCE LEVEL OF 5,762 MENTAL DEFECTIVES EXAMINED IN THE SOUTH DAKOTA SURVEY, 1925–1935

Age in years	*Total*	*Moron*	*Imbecile*	*Idiot*
0–4	73	14	29	30
5–9	919	649	205	65
10–14	2,192	1,856	261	75
15–19	1,446	1,229	178	39
20–24	279	135	108	36
25–29	208	106	79	23
30–34	189	92	78	19
35–39	133	57	66	10
40–44	108	56	39	13
45–49	68	37	27	4
50–54	60	32	25	3
55–59	29	12	11	6
60–64	30	14	14	2
65–69	14	7	4	3
70–74	5	3	2	0
75–79	6	2	3	1
80–84	2	0	2	0
85–89	1	1	0	0
	5,762	4,302	1,131	329

defectives classified, 529, or 9.2 per cent, belonged to the special types. Of these, 19 were (endemic) cretins, 189 (idiopathic) epileptics, 34 hydrocephalics, 22 microcephalics, 136 mongolians, and 129 paralytics. In terms of percentages 3.5 of the total group of 5,762 were epileptic, 2.3 mongolians, and 2.2 paralytics.

Two cross-sectional studies of the number of mental defectives in certain age groups of the population of the state have been made. The first study includes the children six to sixteen (inclusive) and was completed in 1930. This survey was as complete as it is possible to make a survey of this

TABLE 4.—SPECIAL TYPES OF MENTAL DEFECTIVE CLASSIFIED IN THE SOUTH DAKOTA MENTAL SURVEY

Age in years	*Total*	*Cretin*			*Epileptic*			*Hydrocephalic*			*Microcephalic*			*Mongolian*			*Paralytic*		
		Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
0–4	26	..	..	..	4	2	6	5	..	5	..	..	..	5	4	9	3	3	6
5–9	119	1	4	5	15	13	28	3	5	8	..	2	2	25	26	51	11	14	25
10–14	135	1	1	2	20	18	38	4	6	10	3	3	6	17	20	37	24	18	42
15–19	77	2	..	2	14	9	23	2	1	3	4	1	5	8	9	17	17	10	27
20–24	54	3	1	4	14	13	27	..	2	2	..	2	2	2	3	5	5	9	14
25–29	36	1	1	2	7	9	16	2	2	4	2	..	2	4	4	8	3	1	4
30–34	40	1	1	2	12	13	25	2	..	2	2	..	2	2	3	5	3	1	4
35–39	17	1	..	1	6	5	11	..	..	..	..	..	..	1	2	3	1	1	2
40–44	8	..	..	..	2	2	4	..	..	..	1	2	3	..	..	..	1	..	1
45–49	4	..	..	..	..	4	4	..	..	..	..	..	..	..	..	..	..	..	..
50–54	6	..	1	1	4	1	5	..	..	..	..	..	..	..	..	..	..	..	..
55–59	5	..	..	..	..	2	2	..	..	..	..	..	..	1	..	1	1	1	2
60–64	2	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	1	1	2
Total	529	10	9	19	98	91	189	18	16	34	12	10	22	65	71	136	70	59	129

TABLE 5.—SEX AND INTELLIGENCE LEVEL OF MENTAL DEFECTIVES IN WHITE POPULATION OF SOUTH DAKOTA AGED SIX TO SIXTEEN, INCLUSIVE, AS REPORTED BY MENTAL SURVEY 1925–1930 *

		DEFECTIVES								
		Total			*Idiot*		*Imbecile*		*Moron*	
	TOTAL POPULATION GROUP	Number	Per cent of total group	Per cent of same sex	Number	Per cent of total group	Number	Per cent of total group	Number	Per cent of total group
Male	80,012	1,229	.775	1.53	56	.035	197	.012	976	0.62
Female	78,201	821	.514	1.05	41	.025	161	.010	619	0.39
Total	158,213	2,050	1.29		97	0.06	358	0.22	1,595	1.01

* Based upon the school census of the year of the survey.

kind. Great care was taken to examine and classify every child within the age group in question who might be mentally defective. Most of the children were examined at school. In the city schools the examinations were made in the principal's office or in some spare room where privacy could be had. In the rural one-room schools the vestibule or the psychologist's car was used in warm weather. The hot-water heater made it possible to give tests in the car in colder weather. Many home calls were necessary in order to examine the low-grade defectives and children temporarily out of school.

A summary of the numbers and percentages of mentally defective white children, six to sixteen years of age, grouped according to sex and intelligence level is given in Table 5. There were in all 2,050. The school census compiled for the identical years in which the survey was made shows that there were a total of 158,213 children between the ages of six and sixteen inclusive. The mental defectives made up 1.29 per cent of this group. Ninety-seven, or .06 per cent, of the total group, were idiots; 358, or .22 per cent, imbeciles; and 1,595, or 1.01 per cent, morons. The ratio of the sexes for the various classes of mental defective was as follows: idiots, 7 males to 5 females; imbeciles, 6 males to 5 females; and morons, 3 males to 2 females.

The proportion of mental defectives in the population six to sixteen years of age varied in the 64 counties of the state from .3 per cent to 3.6 per cent. The median was 1.1 per cent; the mode, 1.0 per cent. The modal counties represented 25 per cent of the school population of the state. Forty-nine of the 64 counties came within a range of .5 per cent of the average for the state. These 49 counties represent 80 per cent of the white school population.

The second cross-sectional study was made on December 31, 1934. A tabulation at that time showed that there were 2,819 mental defectives aged six to twenty (inclusive) living in the state. They made up 1.33 per cent of this age group in the population, which represented 31 per cent of the total population of the state. A classification of these defectives by sex and intelligence level is given in Table 6.

A tabulation of the mental defectives in the ten largest South Dakota towns was made from 1925 to 1930. Table 7

shows the distribution by sex and intelligence level of those in the age group six to sixteen. The proportion of mental defectives in the total school population in these ten towns varies from .7 per cent in town E to 2.3 per cent in town H. In both towns all school children were given group tests as a means of selection. In towns A, C, and D group tests were given to the retarded children by the psychologists. Town B had a school psychologist who examined all retarded children for special classes. Towns F and G had summer classes for the retarded children in 1926 and many of the tests were given at that time. Towns I and J are college towns where group-test ratings of all the school children are available for the selection of the mentally retarded.

TABLE 6.—SEX AND INTELLIGENCE LEVEL OF MENTAL DEFECTIVES IN THE WHITE POPULATION OF SOUTH DAKOTA AGED SIX TO TWENTY, INCLUSIVE, JANUARY 1, 1935

		DEFECTIVES				
		Total		*Idiot*	*Imbecile*	*Moron*
	TOTAL POPULATION GROUP *	Number	Per cent of same sex	Number	Number	Number
Male	103,607	1,622	1.51	63	162	1,397
Female	100,486	1,197	1.19	39	157	1,001
Total	204,093	2,819	1.33	102	319	2,398

* Based upon the State of South Dakota Census of 1935.

A great variation in the number of mental defectives in different areas in the larger towns was found. A comparison of two grade schools in two different sections of town A was made. Each of these schools had an enrollment of over 400 pupils. One of the schools was located near a packing plant and the other in an exclusive residential district. In the first school 19 mental defectives were found and not a single one in the latter.

A survey of the various state institutions is made from time to time. A classification by intelligence level of the inmates at the South Dakota School for the blind, the South Dakota Training School, and the South Dakota Penitentiary is given in Table 8. This table shows that 19.6 per cent of the blind children, 13.6 per cent of the delinquent boys and

TABLE 7.—SEX AND INTELLIGENCE LEVEL OF MENTALLY DEFECTIVE CHILDREN AGED SIX TO SIXTEEN, INCLUSIVE, IN TEN LARGEST SOUTH DAKOTA TOWNS, 1925–1930

TOWN	SCHOOL POPULATION AGED SIX TO SIXTEEN	MENTAL DEFECTIVES											
		Male					*Female*					*Total*	
		Total		Idiot	Imbecile	Moron	Total		Idiot	Imbecile	Moron		
		No.	Per cent of male school population	No.	No.	No.	No.	Per cent of female school population	No.	No.	No.	No.	Per cent of school population
A	6,261	36	1.1	1	7	28	31	1.0	2	5	24	67	1.1
B	3,735	26	1.4	2	3	21	16	0.8	1	2	13	42	1.0
C	2,129	11	1.0	1	1	9	12	1.1	3	1	8	23	1.1
D	2,091	23	2.1	..	4	19	12	1.2	..	2	10	35	1.6
E	1,802	8	0.9	..	1	7	4	0.4	..	1	3	12	0.7
F	1,697	8	0.9	..	1	7	6	0.7	1	2	3	14	0.8
G	1,290	7	1.1	..	4	3	7	1.1	..	1	6	14	1.1
H	1,012	16	3.2	..	3	13	8	1.6	1	3	4	24	2.3
I	938	7	1.5	..	..	7	10	2.1	1	1	8	17	1.8
J	861	6	1.4	..	..	6	7	1.4	1	..	6	13	1.5
Total	21,816	148	1.34	4	24	120	113	1.03	10	18	85	261	1.20

girls who were committed to the training school, and 11.2 per cent of the prisoners were mentally defective.

A study of the relation between intelligence and offense in the prison group shows that the mentally defective of this group tended to commit certain types of crime. Twenty-one per cent of the assaults with intent to do bodily harm, 17 per cent of the homicides, and 16 per cent of the sexual offenses, were committed by the mental defectives. On the other hand, out of 136 mental defectives only one committed burglary and

TABLE 8.—DISTRIBUTION BY INTELLIGENCE LEVEL OF INMATES OF THE SOUTH DAKOTA PENITENTIARY, THE SOUTH DAKOTA SCHOOL FOR THE BLIND, AND THE SOUTH DAKOTA TRAINING SCHOOL *

		Percentage of each intelligence level						
Institution	*Number of inmates*	Mentally defective	Borderline	Dull	Average	Bright	Superior	Precocious
South Dakota Penitentiary	946	11.2	19.0	29.2	29.1	9.3	2.1	0.1
South Dakota School for the Blind	46	19.6	13.0	17.4	28.3	15.1	6.6	...
South Dakota Training School	339	13.6	27.0	26.3	23.0	10.0	...	...

* Examinations were conducted at various irregular intervals over the period 1925–1935.

only three committed robberies. The three morons who committed robbery were regarded by the prison authorities as the "tools" of brighter "yeggmen." No embezzlements were committed by the mentally defective or border-line group. A distribution by intelligence level of the prisoners whose offenses were grand larceny, forgery, fraud, and violation of the prohibition laws showed about the same proportions as the total group. These crimes seem to be more or less common offenses for all of the various levels of intelligence found in prisons.

A complete survey of the South Dakota School for the Deaf has not been made. The annual enrollment is usually about 100 pupils. At one time six mental defectives were found among the backward pupils selected for examination.

About 640, or 11 per cent, of the 5,762 registered mental

TABLE 9.—SEX AND INTELLIGENCE LEVEL OF 1,088 MENTAL DEFECTIVES WHO HAVE BEEN PATIENTS AT THE STATE SCHOOL AND HOME FOR THE FEEBLEMINDED

	Total	*Idiot*	*Imbecile*	*Moron*
Male	661	118	274	269
Female	427	86	192	149
Total	1,088	204	466	418

defectives are in the State School and Home for the Feebleminded. If the proportion of 1.3 per cent found among the children of school age be used as a basis for an estimation of the incidence of mental defect in the general population, there are approximately 8,776 mental defectives in South Dakota. This estimate would mean that 7 per cent of the actual number of mental defectives are segregated at the present time.

During the survey a total of 1,088 mental defectives were classified who had at some time been in the State School and Home. A distribution of this group by sex and intelligence level is given in Table 9. It will be seen that 204, or 19 per cent, were idiots; 466, or 43 per cent, imbeciles; and 418, or 38 per cent, morons. The tendency to segregate low-grade defectives is indicated by a comparison of these percentages with the 6 per cent idiots, 19 per cent imbeciles, and 75 per cent morons found in the total registration for the state.

Since the law for control went into operation in 1931, the State Commission has had 1,351 mental defectives—743 males and 608 females—committed to its supervision and control.

A classification of this group by sex and intelligence level is given in Table 10, which shows that 67 were idiots, 576 imbeciles, and 708 morons.

Registration of Mental Defectives.—The registration of all mental defectives who are identified is an essential part of

TABLE 10.—SEX AND INTELLIGENCE LEVEL OF THE FIRST 1,351 MENTAL DEFECTIVES COMMITTED TO STATE CONTROL IN SOUTH DAKOTA, JULY 1, 1931, TO JUNE 30, 1935

	Total	*Idiot*	*Imbecile*	*Moron*
Male	743	44	298	401
Female	608	23	278	307
Total	1,351	67	576	708

the program of the South Dakota State Commission. In 1935 the registration showed 850 mental defectives per 100,000 population. All classifications and records of mental defectives in South Dakota are registered and filed with the State Commission at its office at the State School and Home for the Feebleminded at Redfield.

It might be well, at this point, to enumerate some of the data and services that are made available through the maintenance of a central registry. The statistical data of this study are an example of the information that is available at such an agency. For example, inquiry is often made as to what happened to all the 5,762 cases in the way of treatment. To summarize, the records show that 2,082, or 34 per cent, of the number registered by the state commission have been subjected to one or more methods of social treatment, as follows: 1,351 have been committed to permanent supervision and control. Of this number 163 have been committed to custodial care at the institution for the feebleminded and 78 have been sterilized. There are 1,088 of the 5,762 mental defectives registered who have been admitted as patients to the institution. The total number of sterilizations is 262. There has been some overlapping of treatment, as already indicated.

It is the program of the State Commission eventually to take over the supervision of all individuals whose mental defectiveness can be legally established. The status of feeblemindedness is determined by a subcommission for the control of the feebleminded. There is such a board in each county. This board is composed of the county judge, the state's attorney, and a physician who is appointed by the board of county commissioners. This subcommission acts as a judicial and examining board. It holds hearings and investigations for mental defectives upon information filed by the state commission, by officials, or by individuals who are qualified to file a complaint upon belief that an individual is feebleminded and a fit subject for supervision and control.

The records of the mental defectives at the central office are cumulative. The registry of an individual is opened with the recording of his mental examination. A summary of the report is transferred to other records for convenience when the individual is committed to the institution. Other trans-

fers are made when he becomes a ward of the state or is sterilized. Items such as death or removal from the state are recorded. The record is never destroyed as it may contribute to a genealogy.

The state commission maintains a continuative census of the mentally defective in the state. This means a resurvey of each county every two years. These resurveys often discover mental defectives who are related to those already registered. As already stated, the census of mental defectives is approximately complete only for children of school age, but if continued for a generation will be complete for the general population above six years of age.

The practical value of such a registry to the state commission should be obvious. It is necessary in order to maintain proper supervision of those who are under state control. It is the source from which information is obtained for new commitments. It aids in the investigation of cases for custodial care, which is especially helpful when facilities for such care are limited. In South Dakota preference for admission to the institution is given to cases who are a social problem in the community and those who are an unbearable burden in the home.

There is much useful information about mental defectives to be gained by the continuance of such a registry, in which the life histories of large numbers of defectives will eventually be recorded. It would be helpful, for instance, to know at the end of a generation how many of the 5,762 mental defectives registered have developed epilepsy; how many have served terms in a reformatory or prison; how many have been permanently or temporarily dependent; how many at some time or other have been custodial cases at an institution for the feebleminded; and how many have developed psychoses. These are some of the questions that can be answered if cumulative records are permanently maintained. Such records would obviously yield many data of predictive value.

CHARLES SHERMAN LITTLE

CHARLES SHERMAN LITTLE, M.D., Sc.D., died at Letchworth Village, Thiells, New York, on June 6, 1936.

Dr. Little, an outstanding physician in the care of the feebleminded, was born in Webster, New Hampshire, on February 12, 1869. He graduated from Dartmouth College in the class of 1891, obtaining the degree of B.S., and after working for a period with railroad and insurance companies, returned to Dartmouth Medical School for his medical education, graduating with the class of 1896. During the following years he became a member successively of the staff of Tewksbury State Hospital, Taunton State Hospital, McLean Hospital, and the New Hampshire State School for the Feebleminded, where he was superintendent from 1902 to 1910. On July 1, 1910, he became superintendent of Letchworth Village, in which position he served until the time of his death.

In July, 1918, Dr. Little was commissioned captain in the Medical Corps of the United States Army, and served in France from November, 1918, until April, 1919, returning to his position as superintendent of Letchworth Village after his war service.

On July 1, 1935, the twenty-fifth anniversary of Dr. Little's superintendency was celebrated, and the cornerstones of the last buildings to complete his plan of development were laid on that occasion in the presence of a distinguished group of people. It is given to few men to erect as great and as distinguished a monument during their lifetime as Dr. Little has done in the planning, building, and organizing of Letchworth Village, and his wisdom, vision, and humanitarian thought will endure for many years in this great institution.

No better characterization of this man can be given than was written by President Ernest M. Hopkins of Dartmouth on June 20, 1933, when Dr. Little was awarded the honorary degree of Doctor of Science from that college. I will quote it in large part:

"Outstanding leader in the betterment of conditions for handicapped groups of humanity; reticent in expression of the creative instinct which is yours and diffident in the presence of appreciation of this; humble in spirit, but forceful in action; with no thought of seeking for it, you have won public confidence and the respect and esteem of professional associates. Reared in the rugged school where successful achievement was contingent upon long hours and arduous toil, you have been an exponent of the Apostle's injunction to endure hardness. Distinguished in the years of your athletic career for sportsmanship in games, you have applied this principle to conditions of life. You have made unfortunates of lesser privilege and those of undeveloped minds your special responsibility; you have taught society to understand the needs of these and to make provision for them; and always in care of them you have proved yourself a master in planning and a genius in administration."

Dr. Little was for many years a member of the Board of Directors of The National Committee for Mental Hygiene and always took an active interest in its work for the betterment of conditions for the mentally ill and, especially, for the mentally defective.

In 1902, Dr. Little married Tertia Claire Wilton, who died on October 23, 1918, leaving two children, Barbara and Sherman Little, who survive him. In 1919 he married Daphne Watson Perkins, who also survives him.

Dr. Little played the game of life eagerly, courageously, and devotedly, and won the crown that is bestowed upon great leaders.

ARTHUR H. RUGGLES

BOOK REVIEWS

MENTAL HEALTH: ITS PRINCIPLES AND PRACTICE. By Frank E. Howard and Frederick L. Patry, M.D. New York: Harper and Brothers, 1935. 551 p.

This book is a careful and studied effort to present the best modern thought on how to live happily and effectively from the point of view of contemporary psychiatry and psychology. "A major aim of this book is to help the student and professional worker (educator, physician, nurse, social worker, lawyer, clergyman, etc.) to construct a view of his mental organization which will enable him to avoid the more common unwholesome or pathological deviations from mental health." Another aim is to furnish practical procedures for these workers. Representative "case studies" are frequently given to illustrate the text, and a number of these are made available in rather full detail in the appendix.

The authors emphasize mental deviations and their treatment, averring that distinctions between "normal" and "abnormal" are neither helpful nor necessary for an understanding of human nature or for the treatment of human problems, and that our knowledge of deviation is perhaps more illuminating and practical than that of the so-called "normal."

The book follows the usual arrangement of textbooks, providing methods of study after each chapter, such as "Questions for Discussion and Review" and references "Recommended for Further Reading." There is a short glossary of the more common terms at the end of the volume.

The authors duly acknowledge their great indebtedness to Dr. Adolf Meyer, to the exposition of whose psychobiological system a good portion of the book is devoted. Some of the material is admittedly a summary of Dr. Meyer's views, especially those chapters which describe his particular psychology and psychiatry—*Ergasiology* and *Ergasiatry*.

This is a difficult book to review in the usual summary fashion as it covers so much ground and touches upon so many fields of thought. There is considerable material that might be questioned from one point of view or another, and the wisdom of including certain topics might also be questioned when one takes into consideration for whom the book was mainly written. The reviewer, therefore, will only sample and comment here and there.

The first chapter strikes the keynote. The book is in short a Quest

for Happiness through the means of psychology and psychiatry (particularly the authors' own system). Is there at the present time a Science of Happiness? the authors properly ask, and answer largely in the negative. "Happy living is an art and must be learned by practice, but the science of human behavior can point out some conditions and principles to guide us in our practice." And the book proceeds to do this in a fairly enlightening way.

But many questions arise at this point in the mind of the reviewer to which he finds no answers or which, when discussed, are treated in a fumbling and more or less incomplete way. Some of these questions are:

1. Are psychology and psychiatry of themselves sufficient for a Quest for Happiness?

2. Is Science, as it is now understood by most scientists, alone of avail for happiness? What of Ethics?[1]

3. If happiness is a concern not of the individual alone, but of society, what do contemporary psychology and psychiatry offer to present-day social philosophy, particularly in the field of conduct? What about the welfare of society and the conflict between the desires of the individual and the demands of society? Does not psychiatric practice revolve more or less around the individual?

4. Should not any system that promises a tithe of happiness give a large portion of its space to the problems of sex and economics? One chapter of some 14 or 15 pages is given over to a more or less superficial discussion of sex, that admittedly important phase of human nature, and the numerous allusions throughout the text only slightly illuminate this topic. Economics, also an extremely important topic, is given only lip service in the book's treatment of it. The average adult will find little help from the pages of this volume in so far as his own sex or economic problems are concerned.

The book should prove more helpful, however, to the adult in his capacity as parent or teacher as it contains much excellent material

[1] Basic to any discipline which concerns itself with mental health or the Quest for Happiness is the fundamental relationship between science and ethics. After first defining science as the search for truth (admittedly only one of many definitions) and ethics as the search for right methods of living (again a definition not all universal), one has to consider the bases for establishing truth in the instance of either discipline. Modern science derives its laws and generalizations from facts drawn from nature, while ethics, having to do with "norms" of conduct, has to go beyond facts appreciable by the senses. It concerns itself, for example, with questions relating to duties and obligations between individuals. Science is concerned with the indicative, while ethics deals with what one ought to do. In the opinion of the reviewer, contemporary psychology and psychiatry have illuminated human knowledge with a great deal of information as to *how* people behave, but very little as to how they *should* behave, especially in the realm of their larger obligations to society.

on the handling of the school child. One of the authors is a professor of education and the other a psychiatrist who for many years has practiced his profession in the field of education. The reviewer, however, wonders how much of the material that is offered can be safely utilized by teachers and parents, as a great deal of it requires much experience in its use. The authors seem at times to be somewhat overenthusiastic in urging parents and teachers to employ these techniques, or most of them, although here and there they do warn of the danger in the use of psychological and psychiatric procedures by untrained persons. In general, the authors do not offer any definite measures of discrimination. While in one place in the book they recognize the overcrowded day of the average school-teacher, the program of mental hygiene which they offer requires so much time that she could hardly put it into practice, not to mention her lack of training, so important with the techniques involved. We see this particularly in Chapters 14 and 15 which describe "methods of reconstructing personality and behavior problems." The first of these chapters describes a fairly intricate method of personality study, adapted from that utilized by Dr. Meyer for his medical students, and the second describes a psychobiological balance chart which very much resembles a detailed psychiatric examination.

Further, much of the book is written in rather technical language, which in itself should not be considered a criticism were it not for the fact that it was written mainly for the non-psychiatrically trained person. In those instances known to the reviewer where the book has been used in classes for teachers, the complaint has occasionally been made that it is too difficult to be understood by the average teacher.

Nevertheless, the reviewer values the book because it contains a great deal of sound information. One gains an appreciation of the psychobiological thinking represented by the school of Adolf Meyer. The case studies are excellent in giving the lay person insight into the mechanisms of human behavior (formulated usually at a more or less superficial level), as well as into some of the ways in which the psychiatrist handles and treats the various problems of children and adults.

A reading of this book together with Leo Kanner's recent *Child Psychiatry*,[1] will give one considerable insight into a school of child guidance dominated by Meyer's psychobiology. Both are well worth reading, especially by the advanced student.

Massachusetts Society for Mental Hygiene, Boston.

HENRY B. ELKIND.

[1] *Child Psychiatry*, by Leo Kanner, M.D., with Prefaces by Adolf Meyer, M.D., and Edwards A. Park, M.D. Baltimore: Charles C. Thomas, 1935. 527 p.

EMOTIONS AND BODILY CHANGES; A SURVEY OF LITERATURE ON PSYCHOSOMATIC INTERRELATIONS, 1910–1933. By H. Flanders Dunbar, M.D. New York: Columbia University Press, 1935. 595 p.

This book is a compendium of the important contributions on the subject of psychosomatic interrelationships since 1910. A great deal of material has been gone over in a careful and systematic manner and arranged under suitable headings. The material has necessarily been selected from the great amount available, and a question may be raised as to whether the selection given is the most desirable. In the reviewer's opinion, the author has done an excellent and satisfactory piece of work, and while there will of course be some individual differences of opinion, the field seems to have been covered in a satisfactory manner. With so large an amount of space devoted to abstracts of articles, obviously little space could be given to discussion. What discussion there is fits in with the general concept of American psychiatry at the present time and may be said to follow Adolf Meyer's psychobiological point of view. Some of the psychoanalytical terminology is also used, but the author seems to have kept a rather good middle ground in the discussions. In general, it may be said that the book points out the interrelationship between the physical and mental and brings out the modern concept of psyche and soma as simply different aspects of the total personality.

The book is a rather pretentious undertaking. Obviously, it would take a series of volumes to cover the subject fully, but in the amount of space available the author has given an excellent reference work to those who wish to familiarize themselves with the literature on the subject. It is a book that for a number of years will fill a distinct need.

KARL M. BOWMAN.

Bellevue Psychiatric Hospital, New York City.

I KNEW THEM IN PRISON. By Mary B. Harris. New York: The Viking Press, 1936. 401 p.

In direct, simple, and somewhat anecdotal fashion, this book describes Dr. Harris' experiences as superintendent in turn of the women's workhouse on Blackwell's Island, the women's reformatory at Clinton Farms, the New Jersey State Home for Girls, and the Federal Industrial Institution for Women at Alderson. It is amazing to discover how adequately the author has used what purports to be an almost naïve chronicle of events as really a compelling and quite unanswerable plea for prison reform. Not that the situation itself has failed her—for, granting Dr. Harris' ability and subtlety

in making her points, her experience has included an unusual train of events.

For instance, she had no axe to grind. She accepted the superintendency at Blackwell's Island without ever having previously even visited a prison. In fact, her career up to that time had been devoted to studying and teaching Latin and Sanskrit.

For instance, Dr. Harris has headed four quite dissimilar institutions and has crowded these experiences close enough together to allow of vivid and fruitful comparison.

For instance, she went from a "bad" to a "good" and then back again into a "bad" situation. The book gains tremendously from this third superintendency. Here Dr. Harris' theories and personal ability were really tried in the fire. Alderson (the fourth) would have been "too good to be true" coming immediately after Clinton Farms (the second).

For instance, the last nine of these twenty years have been spent as superintendent in a new institution largely planned by Dr. Harris and with relatively adequate resources for executing her plans.

Accepting the superintendency of the Women's Workhouse on Blackwell's Island in 1914, the author found herself for four years the head of an institution typical of the worst that prisons have to offer in this country. Crowding, the curse of the short sentence (often as short as three days), complete absence of any sort of occupation for the prisoners, lack of even the most elementary provisions for classification, the control of everything and everybody through fear and petty favoritism—these are but samples of her problems. During these years she came to believe (1) that the prison rather than the prisoners incited prison riots; (2) that the dominant drive in these pathetic residents which kept them from ever starting "on the better road" was an ignorant sort of pervasive fear; (3) that every person alike ("keeper" as well as prisoner) would respond to faith; and that (4) a prison could do nothing for its inmates unless its community life essentially paralleled the life one hoped the prisoner would live when set free. These beliefs grew against every sort of discouragement. The workhouse served its purpose well—by 1918 Dr. Harris had a firmly developed philosophy as to what such an institution for women should be.

Then came a year as superintendent of the Clinton Farms State Reformatory for Women (New Jersey). The institution was relatively small, the sentences were of sufficient duration to permit of real development of the inmates, and there was already present a tradition of self-government and of trust and faith in the inmates' desire to reconstruct their lives. Despite the hardships of a terrible winter and of other problems incidental to any prison, one has the

feeling that this experience was "too easy" for so gallant a crusader as Dr. Harris. Yet it was probably quite a necessary way of reaffirming her faith in real prison reform. By now she had proof that hardened keepers were made so by the prison system just as much as were hardened inmates—that in the "poorest" of material was real sympathy for those in despair and joy in hard struggle for their reclamation, if only the old, easy, inviting clouds of fear and distrust could be cleared.

The six months of war work under Mrs. Falconer—dealing with the detention camps—commanded Dr. Harris' energy and ability. But the reader feels that it did not appeal to her heart. The petty struggles, the mass of arrangements, the pulling and hauling for this and that, sharpened her wits, matured her executive ability, unquestionably gave more self-reliance to this student of ancient languages who so oddly had been suddenly dumped at the very forefront of prison reform. But this period remains an interlude.

In May of 1919 the author went to the superintendency of the Trenton State Home for Girls (New Jersey), to remain six years. Here is the high light of the volume. Every form of trouble was present at the start. The girls had been sent for punishment and were ruled by compulsion; the physical equipment was old and inadequate, and constant riots and rebellion were rapidly clearing out such equipment as there was. More than that, for many months conditions continued to become worse. Such freedom for the girls, such faith in them as Dr. Harris so firmly believed in—these were license to a cynical, rebellious, unstable lot who were bent on returning to Society what they had received. Here also were Dr. Harris' methods first systematically criticized by the public and press. Her fight through this to an institution of self-government by the girls, of busied activity for all, of an excellent school, of careful and constructive classification of each inmate, of relative success in weeding out the psychopathic and feebleminded—this is an epic to be read by all those who become discouraged over the difficulties that face social reform.

The nine years as superintendent at Alderson have been years of planning, and then operating with a relatively free hand, an institution that really attempts to embody an enlightened and forward-looking program of reconstruction. Self-government by the inmates—of course. Complete absence of bars, "guards," the restraints of fear—of course. Does it "pay"?—of course. Even if some number-minded critic discovers an alarming degree of recidivism, no one can read these pages without realizing that something in the way of human relationships, something in the way of building clear roads and acquiring the desire to travel them has been happening to these

women. There is a great deal yet to be done and Dr. Harris has had her troubles at Alderson, but the Federal Industrial Institution for Women is (and the book shows it) a goal to be aimed at by many another prison in this country. When we have attained that goal, we shall be able to see the next steps.

We whole-heartedly recommend the book to every intelligent layman. It is a well-written, compelling picture of the whole mess of penal institutionalization in this country. It manages in a sane, sober, reasonable way to show the steps needed for reform. Nor are these impossible procedures. Dr. Harris' various solutions to problems have a suspiciously regular way of succeeding, so that "we never had any more trouble on that score." Yet this absence of any of the dismal failures which are the lot of each one of us who works in these fields is a rather necessary part of the propaganda which the reviewer hopes this book will so much further. An autobiography, it is really an appeal for rational treatment of a miasmic problem.

We advise trained social workers not to read the book. It is too disturbing. This woman without a whit of training or experience has been changing people—has been *doing* things. Here's a book completely innocent of even one case history, but only a stubborn fool would deny that it is full of grand therapy—of people looking at themselves and life differently. The expert and the person of polished technique are painted in uncomplimentary colors, but the book is full of glowing, rich experience and of a technique that is realistic and of a character to solve in apparently constructive fashion the puzzles of acute, crashing, domineering human crises. The book pins its faith upon trust in and sympathy for every person, along with a common-sense, direct, "superficial" approach to the problems of human adjustment. It's rather too bitter a pill for us technical workers. One hopes, however, that (where taken) it will have the therapeutic value it deserves.

JAMES S. PLANT.

Essex County Juvenile Clinic,
Newark, New Jersey

DIAGNOSTIC CRIMINOLOGY. By Lowell S. Selling. Ann Arbor, Michigan: Edwards Brothers, 1935. 155 p.

This book is written for those physicians who, with relatively little psychiatric knowledge, are being asked to give psychiatric service to their juvenile and criminal courts. After depicting the development of the work, the author devotes a fair share of the book to a description of the various elements in the examination of the adult offender, a similar exposition for the examination of the juvenile offender, and then a listing of the more common syndromes en-

countered. An appendix, giving a sample letter to be written to the court for each of the syndromes described, indicates the general level of the volume's approach to the subject.

The best part of the book is its twenty pages on "the psychiatric interview" with the child. The rest is a catalogue of what must necessarily be done in rapidly and rather painlessly finishing a task that one does not like to do.

The printing process employed is emphasized by the publishers. The entire book is photolithographed from perfect typescript. This leads to some blurring of letters and to an unevenness of the right-side margin that at first is a distinct strain to the eyes. This feeling passes after a few pages, however, leaving the reader ready to accept the format as assuring the possibility "of the publication of scholarly and technical books in small editions."

JAMES S. PLANT.

Essex County Juvenile Clinic,
Newark, New Jersey.

APHASIA; A CLINICAL AND PSYCHOLOGICAL STUDY. By Theodore Weisenburg, M.D. and Katharine E. McBride. New York: The Commonwealth Fund, 1935. 634 p.

The authors of this comprehensive study have attempted to bring the problem of aphasia, one of the most debated neurological problems, up to the point of our actual knowledge and to clarify its subtle details by psychological approach. They stress the difficulties and handicaps of the various types of orientation that have been in vogue: the neurological approach which has endeavored to determine the nature and extent of the pathological process underlying the disturbed speech function and to give a physiological explanation of the organic speech disorder; the insufficient and poorly validated psychological-test methods; and the incomplete anatomical examination, each of which is responsible for the more or less uncertain position the aphasic problem has reached.

The authors attack the problem by introducing standardized "test-batteries," which measure the "psychological changes" in aphasia; by a more rational classification of types; and by a comparative neuro-anatomical survey.

After a valuable review of the various phases the study of aphasia has undergone and a summary of the representative work of the most outstanding students, covering also the related apraxias, agnosias, and amusia, they proceed to a critical analysis of the tests which have been applied before and of their own test methods.

Since practically no pure types of aphasia seem to exist, they find

the terms "predominantly expressive" or "predominantly receptive type" more adequate than the old terms "motor" or "sensory" aphasia. In the expressive-receptive form are included those mixed types which present so grave a deficit of speech function and speech understanding as not to allow classification under the two main groups. (This group is illustrated by cases which show the most varied scores in non-language performances.)

A special place is reserved for a fourth group, the "amnesic" type of aphasia, as described by Goldstein, Pick, and others, with its more isolated difficulty in naming objects.

All groups are represented by a number of cases, each furnished with a clinical report, with a thorough psychological analysis, and with the evaluation of the clinical and psychological progress in parallel.

Careful consideration is given to the psychological situation of brain-tumor cases with aphasia, the findings on control groups of patients without aphasia, the testing procedure and psychological implications of apraxic-agnosic disorders, the comparative clinico-psychological evaluation, the practical problems of reëducation, the variations in behavior and test response, and finally the question of localization and of the character of the underlying pathology. Additional clinical material and further information on the testing procedures are given in two appendices. An extensive and valuable bibliography is added.

This work can be recommended warmly to all those clinical workers and psychologists who are interested in the problem of aphasia. Though it does not bring fundamentally new facts to those who follow a more liberal viewpoint as to the clinical interpretation of the aphasic disorders, the controlled psychological approach by means of standardized test-batteries will tend to encourage the development of more adequate and comparable techniques of investigation, while leaving opportunity for further individual research. The superiority of a well-organized testing procedure, as demonstrated, lies in the fact that, with the test results referable to the efficiencies of the normal as well as to the pre-morbid intelligence level of the test object, and capable of differentiating deterioration processes from mere disintegration of speech function (however artificial the distinction may be), the problems of the aphasic disorder are put in a more tangible field of vision and attack.

The reviewer wishes to express his appreciation for this contribution to the unification of a variety of clinical approaches to aphasia. He feels that it presents a truly integrated methodology worthy of general acceptance.

G. Jacoby Gordon.

Delaware State Hospital, Farnhurst, Delaware.

ADULT INTELLIGENCE; A PSYCHOLOGICAL STUDY OF TEST PERFORMANCES. By Theodore Weisenburg, M.D., Anne Roe, and Katharine E. McBride. New York: The Commonwealth Fund, 1936. 155 p.

This study is an interesting side product of the extensive and valuable investigation of aphasia already reported by two of the present authors.[1] It was a direct response to the need for a control group of normal adults for the interpretation of psychological findings in the study of aphasic patients. The importance of a careful check on this aspect of the problem was recognized at the outset by Dr. Weisenburg as basic to any such study of aphasia as he contemplated, and from this point of view he criticized Head's results with aphasic patients. In 1929 he secured a grant from the Commonwealth Fund for a new attack on the problems of aphasia through a psychological study of normal as well as abnormal cases. This investigation, including the findings on the control group as they bear on the understanding of aphasic subjects, has been reported fully in the volume referred to above. The present study is concerned entirely with the control group considered on its own merits as a representative sample of normal adults. The approach is that of a psychological study through an extensive battery of tests. It must be a source of deep regret, especially to all interested in the coöperative approach to such problems by medical and psychological workers, that Dr. Weisenburg's untimely death has brought to a close this particular association of workers from the two fields, which has been so productive in its contributions.

All investigators who have attempted psychological studies of special adult groups have been hampered by the inadequacy of comparable reference data on a normal or an unselected sample. The authors of this study have done a useful service in their concise survey of studies relating to adult intelligence which constitutes their opening chapter. They appear to have taken into account the major investigations in this field, with the exception of the studies of adult criminal groups, which have been important both for their direct value and for the incentive that they have given to the securing of further data bearing on adults. It seems an oversight for these studies not to be included in this survey.

Succeeding chapters deal with the constitution of the group; the tests used and their results for the group as a whole; comparative findings for men and women and for different age groups; the relationship between various performance levels in the individual case;

[1] *Aphasia: A Clinical and Psychological Study*, by T. Weisenburg and K. E. McBride. New York: The Commonwealth Fund, 1935. Reviewed above.

and correlational findings, including correlations of test results with age, education, and occupation as well as inter-test correlations. The two concluding chapters present a survey of the findings and their significance and the conclusions that the authors feel prepared to draw. An appendix, presenting brief, but essential information regarding the tests, an extensive bibliography, and a very serviceable index complete the monograph.

The study is so detailed in its analysis and the findings are so often negative that it does not lend itself readily to brief summary. Its limitations are largely those that arise from a small sample (seventy cases) where differences which might be expected to be fairly small fail to be demonstrably significant when subjected to the statistical checks which these authors are careful to apply.

The choice of the sample is of major interest in the study and is described with care, since the authors feel that, in a hospital group of this type, they have "tapped a new and valuable source for the study of adult intelligence." The necessity of obtaining an adequate control group for the study of aphasics determined the selection and was responsible for the choice of hospital patients as the normal group. They chose as "the most nearly similar sample of the population, and therefore the best control, . . . patients admitted to the same hospitals . . . but not suffering from any nervous disorder or any condition known to affect mental functioning." Seventy patients—forty-seven men and twenty-three women—were selected from the orthopedic and surgical wards of the three Philadelphia hospitals in which the study of aphasia was being carried on, chosen from the hospital records, or the physician's report, subject to the further limitations that they must be free from present or earlier neurological, mental, or glandular disease, have satisfactory vision and hearing, be under sixty years of age, and speak English as their native tongue. Only white subjects were included. All were in good working condition at the time of the examination and all coöperated voluntarily in the study. (Only 21 per cent of those asked to serve refused.) Comparison with the occupational distribution of the 1930 census for Philadelphia for both men and women and with the educational and occupational data for the adult men examined during the war led the authors to conclude: "The findings are sufficient to indicate that it is a good sample of the middle levels of the population, and as such a valuable basis for the study of mental functioning in the adult period."

The reviewer is not convinced of the correctness of this judgment, which is fundamental to the type of use made of the data in the present study. The inference would appear to be based too much on the negative fact of failure to discover, through the few checks

that could be applied, any striking points of difference. By the time the total group is further subdivided on the basis of sex or age, the numbers are so small as greatly to increase the sense of uncertainty. There is no convincing evidence offered to show that different selective factors may not be operative with reference to the male and female patients brought to the hospital wards, or to the different age groups. If such factors involved a differential selection with reference to intelligence, they would render meaningless much of the exhaustive analysis of the results, in spite of the great care taken to apply statistical checks to all comparisons. To the reviewer the greatest value of the study of this group would seem to be that for which it was originally chosen—that is, as a control group for the aphasic hospital patients, for which the justification is much more obvious.

The tests used, selected as were the subjects with the aphasia study in mind, required ten to fifteen hours when given completely and fell into three main groups: (1) language intelligence tests, (2) educational-achievement tests, and (3) non-language tests. Standard tests were used and standard procedures followed in giving the tests and in scoring. This is an important consideration since it makes possible an extension of the value of the present data through their possible contributions to later studies of adult groups. It may be noted that the authors offer certain criticisms on some of the tests included in the battery, making it clear that the selection would be modified somewhat if the study were being undertaken in the light of their present information. Detailed figures on the tests are given (means and sigmas with their standard errors) for the group as a whole and separately for men and for women and for various age groups. In the effort to get at any characteristic constellations in mental-test performance, the records of individual cases on the various tests were studied. Extensive use was made of correlations in studying the relationships of test results with age, education, occupation, and with one another. The general trend of the correlational findings was in keeping with other studies of test relationships, in that correlations were all positive—except in one instance which was practically zero—and that they were for the most part moderately high. This was also in accord with the negative results obtained in the analysis of the records of individual subjects on the various tests, which led the authors to conclude that it was exceptional to find particular constellations of abilities, but that, on the whole, adults who did well in one type of performance usually did well in others.

Without attempting further summary of the results, which are presented by the authors with great caution to prevent misleading

inferences, the reviewer would indicate again her question as to whether this small group of hospital patients may be accepted as so representative an adult sample as the authors consider it and, accordingly, whether it justifies so extensive an analysis. At the same time the study is an interesting and useful contribution from the point of view of method of approach to the difficult problem of the psychological study of adult groups. A series of studies of this type, utilizing at least a part of the same battery of tests and conducted with the thoroughness that characterized this study, would be of great interest and might have a cumulative value which would make the contribution to the understanding of adult intelligence genuinely significant. Discovery of significant, but small differences which may exist between the sexes or between different age groups at the adult level can hardly be anticipated, however, without larger samples than the present study offers.

MABEL R. FERNALD.
Psychological Laboratory, Cincinnati Public Schools.

MEDICAL SOCIAL WORK. By Harriet Bartlett. Chicago: American Association of Medical Social Workers, 1934. 223 p.

Medical Social Work represents the work of the Functions Committee of the American Association of Medical Social Workers. In this study they have asked themselves, What is this we are doing, why are we doing it, and with what effectiveness are we accomplishing the task of promoting health? Throughout all the answer runs the thread of thought enunciated by John Dewey in *Philosophy and Civilization*—that those who hope to advance science in the future must do so through synthesis of the knowledge that already exists. Its bearing here is that medical social work brings to medicine the social aspects of the case. The physician has the knowledge of the disease; it is the social worker's function to interpret the patient in his setting to the physician, and again to interpret the patient with his disease to himself.

In clarifying their own ideas, the committee abandoned the previously tried statistical method, took twenty-five cases selected at random, and concentrated on three as best showing the types of service rendered. These show how the work of the medical social worker brings to the physician and the hospital that which lies without their grasp under modern conditions of hospital and clinic practice.

It is assumed that the individual needs more than just physical health—that recognition, however limited, gives him a status in family and society. This makes it necessary for the social worker

to deal with the family and the community as well as with the patient.

The question then is, How does this service relate itself to clinical medicine? Here a much debated question in other branches of social work is answered positively. It does so by becoming one of a team, of which the physician is the final authority in treatment and diagnosis. The social worker's contribution is expertness in method of social work and the understanding that this can give to the medical situation. Again we see synthesis between medical pathology and social pathology. It may be working with the patient in order that he may respond to medical treatment. It may take various forms—even that of further research such as a study of occupations in which cardiacs are engaged.

In the study of the three selected cases, we are shown the processes by which this synthesis with medicine is made. The first case is a girl treated for tuberculosis. The social investigation reveals a mortgaged home and an invalid sister. It is believed that there is evidence to support the hypothesis that the strain arising from this home situation was an etiological factor in the patient's breakdown. Cure did not ensue until this was recognized and treated. Preventive work requires attention to these same factors to prevent recurrence.

In the next case, a boy who has lost his right forearm and part of his right hand in an accident is considered. Through legal aid there is adequate financial provision for his care, but ignorant parents and a disheartened boy are to be dealt with in the after-care if he is to become a self-sustaining citizen rather than a pitied cripple.

The third case is one of the terminal care of cancer. Early exposure to tuberculosis and a home lacking in security and happiness may be relative to the disease, but this question, as is pointed out, is academic. The point here is the very perfect acceptance of the inevitable on the part of the patient after the community has functioned to give the best care possible. It is hard to believe that any community would begrudge that care could it know the comfort it gives. A very pertinent question is raised here: How much of such care of a palliative nature can be undertaken without infringing on the law of diminishing returns?

From these three cases the conclusion is reached that the interrelationship between social factors is understood, though not scientifically demonstrated; that physical deprivation and social situations may be deprivations according as they affect the patient or, to use the author's words, according to the psychic component.

After-care, it is seen from the case of the crippled boy, means that persons be helped to adjust to present conditions. As this case shows,

it is not the work of a moment or a week or a month, but the result is a person who is socially useful instead of socially inadequate.

One of the most pertinent findings is that in this time of economic breakdown, the psychological aspects stand out as more important and less successfully dealt with than the physical. This neglect is not surprising when we consider the neglect of these aspects in other fields, but it points to a need of emphasis in training. The conclusion is reached that the understanding of "the social component of illness" is the first and most important step toward the medical social worker's function. How often has one seen this demonstrated when, after an unbelievable number of treatments and operations, a patient in a general clinic is referred for personality and social study, and it is found that the psyche has, as Freud puts it, taken a flight into illness in order to escape the demand of a situation for which the individual feels inadequate.

The patient's attitude is found to be of value and significance in dealing with physical illness, and by her understanding of this the social worker "extends the medical treatment in connection with plans and procedures relating to the patient's activities or care outside the medical institution." The patient must be treated as well as the disease.

Again, in more than half of the cases studied, in the judgment of the writer, measures are necessary to meet the psychological needs of the family. This points to the assumption that while man may not live by bread alone, some of it is necessary and that the financial side cannot be assumed to be non-existent except in the mind of the patient.

The activity of the social worker was devoted to a considerable extent in meeting these financial needs. The greatest amount of effort was put into helping the patient to understand the implication of his illness or handicaps in terms of his usual way of life, and a large amount of activity was directed toward the adjustment of the patient's social rôle and relationship. The most important steps in these cases, and those most frequently emphasized by the workers who carried out the case-work, are environmental adjustment and interpretation, emotional support and guidance, education of family attitudes, and adjustment of the patient to institutional life and incurable disease.

Throughout the study truths are emphasized that in themselves offer material for detailed study—*i.e.*, the utter uselessness of advice unless the patient is emotionally ready to accept it. How many records state that the social worker advises the client to do thus and so, with no regard for what the patient's emotional state is at that

time and what he is capable of doing. An example would be instruction to a diabetic person incapable of understanding its meaning and emotionally so adverse to any advice that the effort to give it not only is a waste of time, but may result in strengthening the resistance.

In conclusion it is again stated that the medical social worker is an integrating factor, a catalytic agent, bringing together the medical and social aspects of the case into a more effective plan.

As is brought out, points that need classification are the understanding of the patient as a personality, and the working with the patient in contrast to working for him. These points are put in terms that would be accepted by any internist or clinician and are free from some of the so-called visionary explanations that to the average physician lack any pragmatic value.

Throughout the work self-criticism is not lacking, and the superficial action which may lead nowhere, while the deeper understanding of the patient is neglected, is pointed out. This is the type of action that looms large in performance with little in the way of result. The lack of wisdom in treating disease without medical advice is also pointed out.

In the opinion of the committee, medical social work, though derived from generic social case-work, is part of the medical care of the sick person. The test of the appropriateness of the social worker's activities will be the degree to which they increase the effective functioning of the medical team in the care of the patient. The social worker, to do this, needs to be more objective, to become less involved in her cases. She must organize her thinking and material with more clarity and conciseness. To any one who has had to pour over voluminous records of activity on the part of the worker to find out what manner of person the patient is, such advice comes as cool air on a humid day. There must be joint thinking on the part of the physician, the social worker, and the patient, all directed toward the goal of health. Flexibility of thinking is recommended. To make a plan and stick to it is not always best. As a parting word, it is recommended that the social side of illness be more closely studied.

To any one who wants to know what medical social work is, or to a medical social worker who wants to know what goals should be striven for, this book is recommended because of its clarity, comprehensiveness, and sanity.

NANCY JOHNSTON.

Richmond, Virginia.

THE FIELD OF SOCIAL WORK. By Frank J. Bruno. Boston: D. C. Heath and Company, 1936. 646 p.

Having dedicated this book to his students, the author has had teachers, students, and practicing social workers primarily in mind, but recognizing the position of social work to-day as one that commands widespread interest, he has regarded the general public also as potential readers. To glance at the table of contents is to be astounded at the scope of the subject matter. The author set himself no simple task in daring to be so expansive for so wide an audience.

The book is more than an introduction to the field of social work, although it could well serve as that since it contains much information which would orient the laity as well as a way of thinking essential to the professional worker. The author describes it as "emphasizing theories, their varying influences, the arguments for and against them and, when possible, the present state of the debate." Thus he not only presents the various elements and influences that operate in social work as it functions to-day, but also makes an attempt to evaluate these factors. Merely to have recorded them would have been an ambitious undertaking and one of distinct value, resulting in a more valid, though perhaps less engaging book. In fact this aspect of it constitutes its professional contribution. The attempt to evaluate so many theories, each with its wide implications, has necessitated a degree of oversimplification which involves the conveying of some partial truths and misconceptions. The thesis of the work is a plea for comprehensive thinking—seeing the whole in terms of the parts and yet as a distinct entity which is not explicable in terms of the parts. Repeatedly the author protests "unilateral" thinking. And yet, in evaluating whole schools of thought in summary fashion, he has seemed to do that which he condemns. For example, in Chapter 18, in which he presents the functional approach to behavior, he discusses five schools of thought in twenty-four pages. In this meager space he has not only presumably presented the major tenets of each school, but has also compared their relative merits and demerits, and has disposed of several with the accusation that unilateral thinking is their primary weakness. Thus one is given the theories of Watson, Jung, Adler, Freud, W. I. Thomas, and the Gestalt theory in a microscopic nutshell. In each instance he has seized on the germinal idea—and disregarded the resultant growth. In contemplating the seedling who could comprehend the tree? The result is that one is given a distorted idea of the wide social implications of these various theories—in fact one's orientation on the functional approaches, as a result of reading this portion of the book, would be pretty much in terms of the popular misconceptions rife in the field.

Practically all progressive thinkers would agree with the author's major thesis. Whether one approaches an understanding of the human being in his social setting from the sociological, biological, psychological, psychobiological, or psychoanalytic point of view, one can see the whole in relation to the parts and comprehend that the entity is not explicable in terms of the parts. Personal limitations rather than limitations in any one of these points of view obstruct the individual when he fails to think comprehensively. There is value in the author's emphasis on this way of thinking. As a background for social endeavor of any kind it is essential. One wishes, however, that he had put more emphasis on the relationship of this philosophic principle to practice, so that the reader would not be left in an impasse. The non-practicing social worker in particular might derive the feeling that the factors interplaying in any situation are so interlocked as to make action futile. One deduction might be that since all the causal factors are significant in the end result, if one cannot do everything, it would be futile to do anything. In fact, a beginner might almost feel that in selecting any one course of action as more important than another, he would be thinking "unilaterally." The point which the author fails to convey is that emphasis on a particular factor does not necessarily constitute "unilateral" thinking—in other words, that one can become a specialist and still not violate the philosophy of seeing the whole in relation to the parts and the entity as distinct therefrom. The social actionist for some reason or other must have felt or thought that social factors were particularly important or he would not have initiated action in this direction. And so throughout the field we have had action in all directions because of emphasis or overemphasis upon one part of the whole as relatively more important or more interesting than another aspect. Briefly, selective emphasis does not imply bias and is a vital element in practice. The professor's prerogative is that of intellectual browsing; he can contemplate the whole with a kind of godlike detachment. The practitioner's human necessity is that of focalizing, and he is necessarily involved to some degree in "unilateral" thinking because his action is concentrated at a single point. The author's repeated criticism of this or that emphasis leads one to feel that focalized action may have led him to deduce bias where it does not exist. There are certain orienting values, however, in the opportunity afforded the practitioner to look at the stars with the professor.

There is much valuable content in the book. The chapter on the functional approach to behavior stands out as a weak section and the criticisms made of it do not apply to the work as a whole. The chapters on the treatment of the mental deficient, the social aspects of

mental deficiency, insanity and the law, and nomenclature are particularly worth-while contributions. The book is divided into four main sections: *Introduction; The Biological Elements; Psychological Aspects of Behavior;* and *Social and Economic Environment.* The forty-two chapters contain a vast fund of information, thoughtfully presented, and interspersed with the author's philosophy—one that reflects a rich experience. That a book at once so condensed and so voluminous should hold one's interest throughout its many pages, instead of becoming a dry compilation of information, is a testimony to the author's vitality. To an unusual degree he enlivens theories and thus stimulates thought. As an introduction to the field of social work, the book should fill a recognized need.

CHARLOTTE TOWLE.

Graduate School of Social Service Administration,
University of Chicago.

COMPARATIVE PSYCHOLOGY. VOLUME I: PRINCIPLES AND METHODS. By Carl J. Warden, Thomas N. Jenkins, and Lucien H. Warner. New York: The Ronald Press, 1935. 506 p.

The publication of Warden, Jenkins, and Warner's three-volume *Comparative Psychology* will constitute a landmark in the history of the science of comparative psychology. Excellent textbooks in the field are already in existence, but here for the first time we find attempted the herculean task of gathering, evaluating, and systematizing into one unitary presentation the enormous existing body of material on plant and animal behavior. Volume I of this exhaustive treatise is subtitled *Principles and Methods,* Volume II will be called *Plants and Invertebrates,* and Volume III, *Vertebrates.* The three volumes together promise to be a complete and critical treatment of the entire field, a treatment so painstaking, scholarly, and comprehensive that it will not soon be superseded.

The present volume, *Principles and Methods,* endeavors to "provide the student with the proper background for an understanding of the survey of plant and animal behavior to be covered in the two later volumes."

The book opens with an excellent history of comparative psychology, with the emphasis placed throughout on the theoretical points of view and the methodology characteristic of the various periods. Since the time of Darwin, the writers show, the prevailing tendency has been to view comparative psychology as a natural science, a trend that has culminated in the present-day emphasis on objectivism and the biological approach. Comparative psychology to-day is to be regarded as a "functional sub-science" of biology and must draw its point of view and fundamental concepts from that

field. Biology itself, however, is by no means of one mind as to what it means to accept a natural-science position. Chapter 2 deals briefly, but admirably with this vexing problem. The ancient battle between teleology and vitalism, on the one hand, and mechanistic doctrines on the other is treated and the assumptions and arguments of the former position rejected. It does not follow, however, that the authors' point of view is a narrowly mechanistic one; no attempt is made to reduce biology to physics and chemistry or to identify natural science with physical science. On the contrary, it is shown that "in so far as the trend in the physical sciences toward 'organicism' in one form or another may be considered fundamental, it means no less than that the basic concepts of biology are at last to be given a place alongside those of physics and chemistry in the general natural science universe of discourse. . . . Mechanistic theory becomes nothing more than another name for scientific determinism." Biology is thus free to develop its own laws and concepts in accordance with the phenomena it finds at its own level of investigation of living organisms.

In accordance with the position taken by the writers that comparative psychology is a sub-science of biology and that the competent student of animal behavior must possess a thorough grounding in that field, Chapter 3 deals with the problems of the origin and evolution of living organisms and the development of the individual, including a discussion of animal learning and the current theories thereof.

In Chapter 4, *The Classification and Analysis of Behavior*, the traditional dichotomy between native and acquired behavior is rejected in favor of a classification based upon "essential types of biological functions." Thus the two main headings of an elaborate and useful classification are "receptive capacities" and "reactive capacities." The methods of analysis of behavior treated comprise observation and experiment, the genetic approach, and the comparative approach. Chapters 5 and 6 deal with the methodological principles and the specific experimental methods of testing reactive and receptive capacities.

The final chapter of the book gives the reader a comparative survey of the morphological and physiological aspects of the groups of organisms that will be treated in detail in Volumes II and III. The classification of organisms according to their genetic relationships is presented here, as well as a survey of the evolution of receptive, reactive, and transmissive mechanisms.

The book is, according to the writers, meant to serve as a textbook for advanced courses and as a reference manual. Judged as such, and as the first complete systematization of the theory and method-

ology of the field, the contribution that the authors have made cannot, in the reviewer's opinion, be too highly praised. The beginning student, however, and the layman will perhaps find the major part of the book too specialized and technical for their purposes.

HULDA REES.

Smith College, Northampton, Massachusetts.

CHILDREN'S FEARS. By Arthur T. Jersild and Frances B. Holmes. (Child Development Monographs No. 20.) New York: Bureau of Publications, Teachers College, Columbia University, 1935. 356 p.

This monograph by Jersild and Holmes makes its approach to certain questions concerning the fears of children via an analysis of four major types of data: (1) records kept by parents who attempted to report accurately all the fears they observed in their pre-school children during a period of 21 days; (2) the childhood fears, especially the earliest, most intense, and persistent ones, which a group of adults alleged they could recall; (3) fears reported in interviews with children of school age; and (4) fear behavior observed in a group of nursery-school children in a series of test situations.

The analyses in the monograph are concerned primarily with revealing the relative frequency of different types of fear (classification chiefly in terms of fear object) and the variation of these frequencies with age, sex, I.Q., socio-economic status, and individual. The investigators also give some attention to an enumeration of the methods used to moderate or eliminate fear as well as of experiences that seemed to create it. Their study does not, on the other hand, make any pretense of having contributed much toward a formulation of the concept of fear, toward an evaluation of methods employed in the control or dissipation of fear, or (with one exception) toward an assessment of current theories regarding the genesis and early development of anxieties. The major object of the research seems, rather, to be a description of developmental trends with respect to the Gestalts capable of stimulating fear, and the identification of a few influences that shape those developmental patterns.

The following are some of the conclusions drawn from the several studies: There is a consistent decline with age in signs of fear in response to insecure underfooting, strange persons, sudden movements, high places, and loud sounds. Contrariwise, fears of the supernatural, of personal inadequacies, and of imagined and anticipated danger increase. Girls probably exhibit more fears than boys when the factor of immediate exposure is controlled. Fearful children tend to be more inept socially and less skilled in motor activities than the relatively non-fearful. Children tend to inhibit to a greater

extent as they grow older the overt expression of their fears. One cannot predict with any high probability of success that a specific child will show fear in a specific situation. Family resemblance with respect to the trait of fearfulness seems to exist to a slight degree. Fears of animals, of body injury, and of social failure seem to be among the more persistent ones. Adults tend to have little recollection of the fears that are most common in the earliest years. At least one-third of the fears arising in childhood that can be recalled in adulthood still leave an adumbration after childhood has been passed. Adults recalling childhood fears report relatively more fears of personal inadequacy than appear in the reports of observers who are describing from direct observation the behavior of young children. Maturation must be taken into account when one is interpreting the course of the development of fears.

Although aware of many of the philosophical difficulties inherent in their problems and procedures, the authors choose to minimize these and to let themselves be dominated largely by practical aims. Whether, in the light of their almost Fabian indirection, their faith in their returns is always justified, is a question.

Realizing that, although each antecedent in a fear episode is a unique Gestalt, classification, with all the violence to the Gestalt that it entails, is essential to any kind of analysis, Jersild and Holmes proceed to develop a system of categories which is more pragmatic than logical. Below are the protocols under which the fear episodes are subsumed:

1. Animals.
2. Specific objects, events, or situations not described as strange or unfamiliar or as having been associated with previous noise, pain, or other ulterior conditioning factors.
3. Sudden movements.
4. Lights, flashes, objects feared by reason of previous association with lights or flashes.
5. Sudden disappearance of persons.
6. Rapidly approaching or passing object.
7. Sudden or rapid motion plus noise.
8. Noises and objects and events feared by reason of association with noise.
9. Falling, displacement, danger of falling, being moved rapidly through space.
10. Pain, painful treatment, painful situations, persons inflicting pain, objects inflicting pain, fears arising as a result of previous infliction of pain, also tactual shocks.
11. Strange, new, unfamiliar objects and situations definitely described as unfamiliar with this factor of strangeness as responsible for fear.
12. Strange persons, active or inactive with reference to the child.

13. Danger or threat of bodily injury or harm other than infliction of specific pain stimulus or corporal punishment, and fear in response to objects or events associated with bodily injury, assault, confinement, etc.
14. Fear in response to warnings, suggestions of danger, statements that a situation or object might be dangerous, and fear displaying apprehension over guilt and wrongdoing.
15. Signs of fear in others.
16. Loss of property.
17. Dreams.
18. Fears and apprehensions concerning personal inadequacies, failure, and ridicule.
19. Fear of robbers, burglars, kidnapers, etc., in the absence of such characters; also fear of dying.
20. Fear of the dark and being alone in the dark, if in connection with fear of imaginary creatures.
21. Fear of being alone (apart from darkness) and fear of being abandoned.
22. Fear of the dark and being alone plus specific mention of imaginary and supernatural creatures or animals feared when alone or in the dark.

The categories do not seem in any sense coördinate. I question, for example, such a one as fourteen—threats—because I feel that the threat is only a means of suggesting the danger in an object or situation. I should like to see, moreover, *all* situations rated for degree of illumination, suddenness of stimulus, degree of immediacy of the danger, degree of strangeness, etc., for I feel that such an approach would yield more than one that not only arbitrarily assumes the aforementioned qualities to be either present or absent in a stimulus-response Gestalt, but also fails to instruct observers to take them into consideration when describing each episode.

The reader can readily see from the protocols some of the dilemmas in which an observer is likely to find himself when given the task of defining the pivotal quality in the fear situation. How much of the Gestalt shall be ignored? How tenuous may the abstraction be? Shall one describe as fear of noise, fear of a ghost, or fear of bodily damage, the shrinking of a child who, when he hears a window rattle, thinks it a supernatural visitor who is knocking? Furthermore, even the system of tallying the fear under each of the three categories does not meet all of the difficulties, for that of lack of uniformity in reporting remains untouched. Observer and experimenter bias must color heavily the pattern of the returns so far as the question of the relative frequency of various kinds of fears is concerned. Those whose thinking has been influenced by Watson or by Adler might give us a picture very different from that which Jersild's observers provide. The authors, of course, admit this and frankly

try to help the reader to an understanding of at least some of their own biases. They confess their emphasis upon novelty, intensity, and unpreparedness. They seem less clearly cognizant, however, of the probability that selective influences are distorting the picture with respect to age trends. I suspect, for example, that to the extent that older pre-school children talk more than do younger and hence probably give verbal accounts of their feelings, a greater gain with age in specificity may appear in the reports than actually occurs. The reactions of older children, to illustrate, would probably be less likely to be identified as fears of mere noise than would those of young children in the same situation, for the older individuals would doubtless make it clear through language that the noise meant a crash and hence danger of falling, or an animal, or a ghost, or ridicule. Meanings such as these latter ones increase with age, it is true; but it is difficult to tell to what extent lack of explicit confirmation of them may be taken as an indication of their absence.

Still another difficulty which an investigator encounters when he attempts to envisage developmental trends on the basis of fear counts is the obvious distortion of the actual frequencies by the tendency of human beings to disguise and conceal their feelings. This proneness to inhibition, the investigators allege, increases with age. No emphasis, however, is given the possibility that this tendency toward concealment and inhibition may not be applied equally to all fears. A child may discover early that to display a fear of falling directs upon him more scorn than does a display of fear of certain animals. It may be more disadvantageous to exhibit fear with respect to the adequacy of one's educational attainments than fear of a robber.

But even if we assume that it were possible to guage accurately the relative frequency with which various kinds of fears are exhibited by a given population, the meaning of incidence differences would still not be clear. Frequency cannot be identified with potency. A low count for fears of a certain type may merely reflect the infrequency of the stimulus in the environment. To state the issue more concretely, let us ask a question or two. Is pain relatively impotent as a fear stimulus, or is it a stimulus that relatively seldom is experienced by the child? Is the greater frequency of fear of falling exhibited in the case of boys as opposed to girls to be construed as due to anything more than the greater activity of boys and its consequent in the form of a greater frequency of immediate danger from falling?

The test situations devised and studied by Holmes are designed to hold constant this factor of immediate exposure and thus to throw into relief individual differences in anxiety. But again the significance of these individual differences is not unequivocal, as the experimenter admits. We suspect that the S's were not equally familiar

with the E who presided over the tests, that the extent of positive conditioning resulting from the inter-test play activities was not entirely constant, and even that a mild fear of the E might in the case of certain children have resulted in ready conformance with all requests the E made. (Fear in the test situation, let us say, was judged largely in terms of refusals.) What disturbs us more is that, even if we assume that inequalities in the test situation were at a minimum, we still would know little regarding the major causes of the differences we observed. One would expect a positive correlation between test score and fear counts made during school activities or time at home, since the test situations contained stimuli types likely to be found frequently in everyday living. A positive r, then, cannot be taken as evidence for a general factor of anxiety. If, furthermore, there were such a factor, we should still be faced with the problem of determining whether the factor were in the category of the constitutional or the result of very broad transfer effects.

Jersild (p. 327) gives a very discriminating statement of the limits not only of his own work, but of all present-day research on fear when he says: "To define the characteristics of the stimuli that are crucial in eliciting fears, to define the factor in the total stimulus-response situation that accounts for the occurrence of fear under some circumstances and not under others, to offer a generalization that would have predictive value, and to define the relative rôles of conditioning and of growth in the development and modification of fear, would require research of a more intense, refined, and genetically continuous nature than any study that has yet been made." In fact, I think him optimistic.

Jersild and Holmes can be commended for the prospecting they have done and for their open-mindedness.

HELEN L. KOCH.

The University of Chicago.

CONFLICTS BETWEEN PRE-SCHOOL CHILDREN. By Arthur T. Jersild and Frances V. Markey. (Child Development Monograph No. 21.) New York: Bureau of Publications, Teachers College, Columbia University, 1935. 181 p.

DEVELOPMENT OF RHYTHM IN YOUNG CHILDREN. By Arthur T. Jersild and Sylvia F. Bienstock. (Child Development Monograph No. 22.) New York: Bureau of Publications, Teachers College, Columbia University, 1935. 97 p.

Like so many of the studies that have appeared from the Child Development Institute at Teachers College, the first of the two monographs cited is based upon the systematic observation of nursery-school children during the free-play period.

Each of the 54 children who served as subjects was observed individually for ten periods of fifteen minutes each. All observations were made at a time when the child to be observed was playing in a group of at least four children. Detailed records were made of all conflicts in which the child was concerned during the time of observation. In as much as not only the child officially under observation, but also one or more other children were involved in each conflict, the effective length of observation per child was appreciably greater than the 150 minutes formally devoted to him. For each child, accordingly, two types of record were obtained—those of conflicts in which the child engaged while he was himself the subject of observation (direct observations) and those in which he engaged with other children during the periods at which they were being observed (indirect observations).

Individual differences among the children were very marked, in respect not only to the frequency with which conflicts took place, but also to their initiation and outcome and the type of behavior displayed. For example, when the data from both direct and indirect observations were combined, it was found that the total number of conflicts per child ranged from 17 to 141. One child was the aggressor in 70 different conflicts; another in only three. Bodily attacks on the other child, such as hitting, pushing, biting, striking with object used as weapon, etc., are recorded 87 times for one child and in not a single instance for another. That these differences are not wholly fortuitous, but represent characteristics that persist for an appreciable length of time is indicated by the results of a follow-up study carried out with 24 of the original group of children who were still attending nursery school after an interval of one year. For these children, a fairly high degree of consistency was shown both as to the relative frequency of conflicts and the individual behavior patterns displayed in the course of the struggle. For another group of 12 children who had been promoted to kindergarten by the time the second series of observations was made, the constancy of the behavior patterns was much less marked, indicating that a change in the social setting may exert a very pronounced influence upon behavior of this type.

The data have been subjected to very minute analysis to show the relationships of various aspects of conflict behavior to such factors as age, sex, intelligence-test scores, etc. There is a brief discussion of the significance of the findings for nursery-school education and a short bibliography.

The second study—that of the development of rhythm (defined as the ability to keep time to music)—made use of an experimental approach in which a mechanical piano was wired in such a way as

to produce a glow of light in a neon bulb at each accented beat of the music. A hand apparatus was devised on which the children could beat time. Each beat depressed a button which caused a light to glow in a second neon bulb. Two separate pieces of hand apparatus, each with its own light connection, made it possible to test two children simultaneously by this method. At the same time a third child reacted by marching to the music. By means of motion pictures a permanent record was obtained through which the rhythmic responses of all three children could be checked for their degree of synchronization with the light that denoted the accented beat.

The study as carried out had four main purposes as follows: (1) to test the dependability and practicability of the method; (2) to ascertain whether or not ability in rhythm varies with such factors as age, sex, intelligence, etc.; (3) to ascertain what tempos in music are best suited to children and whether rhythmic responses are facilitated by artificial simplification of the music; and (4) to study the effect of practice upon rhythmic responses during childhood.

The findings on each head were as follows:

1. The method proved to be easy to use and yielded reasonably consistent results from trial to trial, though some minor sources of inaccuracy were noted.

2. Rhythmic ability improved with age over the period from two to six years and showed (probably) a positive relation to intelligence and to the ability to sing tones of a given pitch, but was unrelated to sex.

3. When a given musical composition was played at tempos ranging from 76 to 186 beats per minute, it was found that the responses of the children improved regularly with the speed at which the music was played. There was a fairly high positive relation between the "hand" and "foot" scores of individual children, suggesting that central rather than peripheral mechanisms are the primary determinants of the rhythmic response. Simplifying the music did not materially improve the performance of the children.

4. Practice for from 15 to 22 periods of about ten minutes each had no demonstrable effect upon later trials.

FLORENCE L. GOODENOUGH.

University of Minnesota, Minneapolis.

ADOLESCENCE—A STUDY IN THE TEEN YEARS. By Lawrence Augustus Averill. Boston: Houghton Mifflin Company, 1936. 496 p.

Dr. Averill is primarily a teacher, who now endeavors to present the data concerning his methods of investigating human behavior at the adolescent level. Employing the case method, he reveals his deep sympathy with individuals and exhibits the background of his wide experience with behavior problems among adolescents.

Many of his studies are presented inadequately merely because there has been a desire to offer them in popular, "human" form rather than in terms of objective scientific terms. The reviewer differs with him sharply as to the validity of reports by college students, even though they may be "rigidly trained in the importance and technic of careful and scientific method," in dealing with personality make-ups and studies of adolescent difficulties. The very fact that such students have so recently escaped from the high-school level and have not fully crystallized into mature standards lessens their value as authoritative, responsible reporters.

Dr. Averill outlines the general problems involving the physical and social factors that enter into the processes of adolescence and deals in a friendly manner with the nature and meaning of the conflicts between generations. His consistent eclecticism is evident in the fact that he places comparatively little stress upon any special theories. One notes in his references a paucity of current material that would be regarded as fundamental by orthopsychiatrists, modern social workers, and students of the psychiatric approach to human problems. To illustrate, among the references appended to the chapter dealing with crime and delinquency, no title by Herman Adler or William Healy appears. The emphasis is greater upon writings emanating from the field of education, and the all-prevailing influence of Stanley Hall dominates the book even to the inclusion of long quotations from Hall's monumental *Adolescence*.

The reviewer is a little uncertain for whom besides normal-school students this volume is prepared. That it contains a large amount of useful data, surrounded by much verbiage of less certain use, is undeniable. While the book undoubtedly interprets considerable adolescent behavior most sympathetically, one feels that there is an emotional content in the writing that somewhat hampers a completely externalized approach to the problems considered. For example, to begin a case history with the statement, "Arni has never had any real childhood," is to create a prejudice before presenting the facts. Examples of this sort occur frequently, as: "Joe has been spoiled from the very minute he was born," or "Patricia is not an attractive girl and never has been." These are not matters of observation; they involve conjectures and subjective absolutes. On the other hand, it is only fair to state that the author, in his approach, emphasizes the significance of mental health and adjustment, and that he has evaluated with due conservatism the effects of our present temporal civilization upon the general behavior reactions of all adolescents, whose very existence constitutes an occasion for conflict. Too much of the old and too little of the newer points of view lessens the value of his general exposition of the subject for students of child-guidance techniques.

The book has many values as a textbook in a normal school, but it is far below the standards required for most postgraduate courses dealing with human behavior and personality at the adolescent level. Its arrangement very definitely makes provision for a student approach rather than for utilization by parents or mental-hygienists during their daily or specific contacts with the dynamic reactions of children in their teens. Each chapter is followed by a series of supplementary problems for special study, together with suggested references. These problems vary in nature and significance, but are thoroughly adequate if the sphere of influence of the book is limited to an introductory study of the adolescent for teachers-in-the-making.

IRA S. WILE.

New York City.

COLLEGE MEN, THEIR MAKING AND UNMAKING. By Dom Proface. New York: P. J. Kennedy and Sons, 1935. 314 p.

The author, hiding behind a *nom de plume,* has written definitely from an experience in which his own personal spiritual organization has operated considerably in his creative procedures. With a religious outlook and a philosophical background of what might be called Victorian stability, he narrates a series of cases of personal redemption. These are diversified under various headings which bear witness to his honest, friendly, creative, and supportive approach, which probably was just as helpful as the author implies, on the basis of its stimulation of students to indulge in self-criticism and to revaluate some of the problems induced by a transfer from home to college, from parental disciplines to collegiate freedoms, from a protected environment to the wide open spaces of a college setting. He reveals what may be called a pastoral approach, in which the technique is based upon sympathy, gentleness, and intuition, supported by a breadth of knowledge and experience, as distinguished from a fundamental psychiatric approach based upon individualized unconscious motives.

A reading of this morale therapy will give the psychoanalyst the jitters and make the psychiatrist wonder what has happened to himself. It will offer the psychologist an opportunity for questioning the meaning of objective psychology, and will enable the orthodox social worker to say, "very reasonable," while ministers will recognize a participation in the scheme of living that is sometimes known as "the quest of the good life."

IRA S. WILE.

New York City.

THE DELINQUENT BOY AND THE CORRECTIONAL SCHOOL. By Norman Fenton, Jessie C. Fenton, Margaret E. Murray, and Dorothy K. Tyson. Claremont, California: California Bureau of Juvenile Research, 1935. 182 p.

The volume under review appears at a very opportune moment when many workers in the field of juvenile delinquency are overwhelmed with a sense of futility in reflecting on their efforts in behalf of the wayward child. With its concise information as to procedures at the Whittier State School for Boys, and their results, this book shows what can be accomplished by a progressive, well-trained group when they attack the problem in the proper manner.

The Evaluation of a State Correctional School furnishes the reader with an excellent background for the material that is to follow. The illustrations are very useful in that they add to the setting and frame the environmental situation of three hundred delinquent boys and a staff of ninety-one adults. In the chapter, *The Delinquent Boy Individualized,* the author states that "a correctional school such as Whittier must attempt to treat the total personality of the problem child if his successful adjustment is to be achieved." We discover that they have done exactly that. From the time the boy enters the school he never ceases to be considered as an individual and the staff can properly feel that the success that has attended their efforts is in large measure due to this principle. The author reminds us that "brutality does not reform, it debases. The harsh, repressive institutions for children are likely to make criminals, not good citizens. The essence, then, of the Whittier program is friendliness and good will." The chapter dealing with the child-guidance conference is well done and follows the usual procedure. To say the least, the child is thoroughly studied physically, psychologically, socially, as well as from an educational and recreational point of view. At the termination of the conference the boy is called in for a friendly talk with the staff and is allowed to choose from among the adults in the school one particular person who is to be his friend and his counselor during his stay at Whittier. The stenographic report of a conference makes the reader feel that it was his privilege to be a guest.

For those who are statistically inclined there are four chapters that will be of particular interest: *Certain Characteristics of Four Hundred Delinquent Boys; An Analysis of the Boy's Own Story; The Interrelationships of Traits of Delinquent Boys;* and *The Program of Academic and Vocational Education.* The tables are well-prepared and the summaries at the end of each chapter complete. No procedure that would develop insight into the exact nature of the material with which they were dealing has been overlooked. Apparently therapy is

developed to its highest efficiency when accompanied by a well coördinated research program.

To the reviewer, the most interesting chapter is *Preparing the Boy for Return to the Community.* This usually neglected part of the boy's training is of tremendous importance at Whittier. There is no use of the words *probation* or *parole,* but, instead, the boy's return to society, whether in his own home or in a foster home, is referred to as *placement.* "The average length of stay at the Whittier State School is about eighteen months. Thereafter, boys are returned to their communities under the placement supervision of the institution. Boys continue on placement until the age of eighteen or for at least one year." There is certainly no evasion of responsibility here. Prior to placement, the boy lives for three months in the Placement Cottage, where he has more privileges. There is a Placement Conference and also a Placement Breakfast twice each month when the boys who are to leave are given a final friendly word of encouragement. The consideration of more conventional problems encountered in a training school for boys has not been neglected. We might mention one extremely important subject and that is personnel. Just what kind of an individual should be employed in a boys' school? No doubt success is largely due to the kindly understanding of those working with the child.

This is an excellent and timely book. The authors have balanced very nicely the different chapters so that nearly all phases of delinquency are covered. There are many references throughout to the bibliography, which is very complete. For those who question just what can be done about delinquency, this is the best answer we have had. It is designed to arouse serious thought on the part not only of social workers and those interested in delinquency, but also of those who are conducting (so-called) training schools. The Whittier group has not achieved the impossible. They have only pointed the way to what can actually be accomplished by the intelligent use of methods and techniques the desirability of which the rest of us acknowledge, but have not the courage to demand.

MILTON E. KIRKPATRICK.
Worcester Child Guidance Clinic, Worcester, Massachusetts.

CREATIVE REËDUCATION. By Frederick Peterson, M.D. New York: G. P. Putnam's Sons, 1936. 112 p.

This is a thoughtful, suggestive, compact little book, every line of which carries significance and conviction. Dr. Peterson, in the course of a lifetime of salvaging invalids by finding them new interests, has acquired a deep insight into potential capacities often buried, or at least undiscovered, by conventional methods of education. Out of

this comes his philosophy of education and reëducation, which will encourage all progressive workers in this field.

"Almost all education down to the Eighteenth Century," he says, "was, like law, founded on precedent and has for us only a sort of paleontological interest." He quotes with zest the great schoolmaster, Sanderson of Oundle, the philosopher of change: " 'Some new freedom, some new principle of life, some new desire to grow, has for a long time been taking root in the minds and souls of men. In this school we do not believe in suppression. We believe in the creative urge.' " Sanderson said that in all his experience with many thousands of boys he had never found a really dull one, one who would not fit into some form of coöperative work and do well his part.

Dr. Peterson believes in the use of the hand and of manual technique, in the service motive, in bodily health as the basis of a successful life, and above all in the discovery of special gifts and aptitudes. "With dormant interests rising like waves from the subconscious, these occasionally make contact with something unforseen in the environment and an emotional illumination results, as a dark cloud passing may reveal a brilliant moon or star." His examples of broken lives repaired by such new interests will be eagerly read by believers in adult education. His faith and enthusiasm are contagious. Educational suggestion may be "a new kind of gardening in the budding soul of mankind. We do not know what new and august races might thereby come to people this rather unsatisfactory globe."

Dr. Abraham Flexner, of Princeton, has said that this book is "sound and simple."

Otto T. Mallery.

Philadelphia, Pennsylvania.

To-morrow's Children. By Ellsworth Huntington. New York: John Wiley and Sons, 1935. 139 p.

This book is remarkable in several ways. First, it has the form of a catechism in which 371 questions are asked, each being followed by the appropriate answer. These questions are grouped, however, into five sections, of which the first deals with the scientific background of eugenics; the second, with its application to problems of population; the third, with the personal application of eugenics; the fourth, with public relationships; and the fifth, with the goal of eugenics. There is an appendix on the mechanism of heredity and a bibliography and index. An introduction serves to formulate for the reader the problem of the need of eugenics before he undertakes the remainder of the catechism. Thus, the first question is, "Why

are children the most valuable thing in the world?" And the answer is, "Because their character determines what kind of world there will be in the future."

A number of questions are then posed in respect to what is being done by euthenical methods to improve the quality of children. It is brought out that these vastly expensive methods have not yielded entirely satisfactory results and that the trouble lies, among other things, in poor inheritance. In contrast with the billions spent on education and medical care, practically nothing is spent on encouraging large families in homes in which the children are likely to be well trained and to have a good inheritance and to discourage large families in homes of the opposite sort. From this it will appear that the author, who has been an outstanding euthenicist, has now come to recognize eugenics as of even greater significance. This varied experience of the author results in an unusually well-balanced treatment of his subject.

The answers to the questions are not always so brief as indicated in the last paragraph. Some of them occupy as much as a page, or more, and the last part consists entirely of the author's statement of conclusions. The ground covered includes such topics as the differential birth rate, the inheritance of physical and mental traits, examples of eugenic selection, positive eugenics and negative eugenics, the operation of sterilization laws, segregation as a method of protecting society against the reproduction of the socially inadequate, the reasons for birth control, and its eugenical advantages and disadvantages.

As one reads, one is impressed by the advantage of the catechismic method as a means of giving information clearly and succinctly. The method, however, is less agreeable to read than the ordinary didactic one, since there is a certain break in continuity in each question and answer. One must conclude, however, that the work has been very well done—that the book deserves a wide distribution and should be of great influence.

CHARLES B. DAVENPORT.
Carnegie Institution of Washington,
Cold Spring Harbor, Long Island, New York.

INTRODUCTION TO PSYCHOLOGY. By Edward S. Robinson and Virginia Kirk. New York: The Macmillan Company, 1935. 368 p.

To quote from the preface of this book, it "aims to give the prospective nurse an opportunity to think psychologically about a wide variety of human problems with which she will be confronted."

The book is essentially a new edition of Edward S. Robinson's *Practical Psychology*.[1] The subject matter of the original text has

[1] New York: The Macmillan Company, 1927.

been little changed. The excuse for the new edition apparently lies in the fact that the problems at the end of each chapter and the illustrations of the psychological principles described have been rewritten from the point of view of nursing problems. These revised illustrations are pertinent and well presented.

Further revisions of the book, however, might well have been made. Too little account has been taken of recent experimental findings. The index is not as complete as one might wish. Also, there are a few statements that might be questioned. For example (p. 19), "Of the two chief classes of effectors—muscles and glands—the former are much better understood and of much greater importance for an understanding of human nature"; or (p. 11), "Psychological knowledge has been gained mainly from the study of the normal human adult. This is due partly to the fact that psychologists have found it convenient to make many of their observations upon themselves."

Objection might also be raised to the somewhat ministerial tone that breaks forth occasionally throughout the book. Note, for example, the following (p. 298), "The voice of conscience refers to that inner discomfort which arises when a morally sound individual commits an unworthy act or entertains the notion of committing such an act." Note also the quotation at the close of the chapter on personality, (p. 334):

> "This above all: to thine own self be true,
> And it must follow as the night the day,
> Thou canst not then be false to any man."

The book, however, is to be commended as an attempt at the solution of an extremely difficult problem. The author of a satisfactory introduction to psychology for use in the instruction of student nurses is faced with an almost impossible task. In addition to fulfilling the requirements of any general introductory text, such a book must be simple enough to be comprehended by students with a high-school background and must be limited enough for presentation in from ten to twenty hours of classroom instruction. The student nurse should find the present volume understandable and not too extensive for assimilation in the time allowed.

MARGARET KELLER.

Butler Hospital, Providence, Rhode Island.

THE NEUROTIC AND HIS FRIENDS. By R. G. Gordon, M.D. London: Methuen and Company, 1934. 85 p.

The well-known author of *The Neurotic Personality* needs no introduction to the psychiatric reading public. In the present volume, written in response to a demand by friends and relatives of patients,

Dr. Gordon states that he has "made no attempt to expound the behavior of the neurotic in terms of psychoanalysis, individual psychology, or analytical psychology . . . but . . . in a sort of manual of first aid, as this purports to be, I thought it better to try to explain the crises which may determine a neurosis in everyday terms within the experience of the ordinary man in the street." With rare discretion he remarks: "It will be observed that I do not advocate that the friends should try to treat the neurotic, for this, in the majority of cases, is a complex and highly technical procedure; but I believe it is possible for them to help him before he comes for treatment and during his treatment by understanding him and exhibiting a correct emotional attitude toward him. It is with the object of assisting toward these desiderata that this book is written."

The five chapter headings indicate the nature of the subject matter: *What Is a Neurotic? The Crises of Life; Types of Neurotic Reaction; The Misconceptions of the Public; Help for the Sufferer.*

Within a small compass the author has condensed much solid information in a clear, attractive style, free from technical verbiage. The book can be heartily recommended to all who are in intimate contact with the neurotic.

HENRY W. BROSIN.

Colorado Psychopathic Hospital, Denver, Colorado.

GUIDE TO PSYCHIATRIC NURSING. By F. A. Carmichael and John Chapman. Second edition. Philadelphia: Lea and Febiger, 1936. 175 p.

This is a very ambitious little book, but because it tries to cover a large amount of material in a small number of pages, the result is rather disappointing. It is evidently written from a medical point of view, with scant knowledge of the needs of the psychiatric nurse. Its purpose is a worthy one and in many ways it is well arranged and informative, but well-trained psychiatric nurses need much more detailed information in order to do intelligent nursing, and attendants should have a much more simplified course than is indicated in this book.

Chapter X, on the symptomatology of mental disease as it should be observed by the nurse on the ward, is quite practical, but the most obvious omission is a discussion of the suicidal potentialities of all mental patients. This is mentioned only briefly in the last chapter. Nothing at all is said about the prevention of escapes and of accidents, very practical problems in all mental hospitals. The "rules of thumb" on page 121 are elementary, to say the least, and insulting to the intelligence of any well-trained nurse. In fact, there are several instances of "talking down" to nurses, an attitude

that does not help the effort which is being made to raise the standards of the nursing profession.

The illustrations are very good and much more practical than those usually found in nursing textbooks.

ELIZABETH S. BIXLER.

Worcester State Hospital, Worcester, Mass.

CONTEMPORARY AMERICAN INSTITUTIONS; A SOCIOLOGICAL ANALYSIS. By F. Stuart Chapin. New York: Harper and Bros., 1935. 423 p.

Social change, we are reminded, is not the only important fact in the life about us. There are also permanencies, rooted in the nature of human beings and expressed in the structures and patterns of existing institutions. These institutions of the local community—*i.e.*, family, school, church, government, welfare agencies—exercise a stabilizing influence in a world in which, for all the impact of large-scale international influences, the individual, personal relations so clearly recognized in, for example, small towns are still the realities among which human beings live and act. Individuals live in a system of social institutions which come so close to the average man that no genuine or lasting social advance is possible without careful consideration of what these local social institutions contribute.

Such a study is offered in these pages by the editor of the Harper's Social Science Series. The author does not attempt to say about these institutions anything that is new or of special interest to the student of mental hygiene. He is concerned chiefly with ways by which their workings can be precisely measured. How far these proposals will go in adding to our knowledge of the institutions—especially in regard to the question how to make their influences work out for better individual living—it is perhaps too early to say.

HENRY NEUMANN.

Brooklyn Society for Ethical Culture.

CHARACTER EDUCATION. By Harry C. McKown. New York: McGraw-Hill Book Company, 1935. 472 p.

This first impression gained from a complete reading of Dr. McKown's monumental volume is that any one of the twenty chapters could easily be expanded into a fair-sized book and yet not exhaust the topic. This impression may indicate either strength or weakness in the treatment, according to one's point of view of what the author tried to do.

After a somewhat disappointing start in the first chapter, in which he summarizes the basic conceptions of character, the author finds his stride in the second chapter, *Character and Modern Life*. In this treatment of the current scene, in family life, industry, national

and international life, politics, propaganda, and crime—to mention a few of the modern phenomena treated—one can only admire the frankness and courage required to put into print such a bold indictment of the present moral order. After reading this chapter and Chapters 7 and 8, wherein the author handles the shortcomings of the movie, the radio, the press, and the home in no uncertain terms, it occurred to the reviewer that perhaps the basic difficulty in character education lies in the fact that a considerable portion of our adult society doesn't really *want* good character, and would be profoundly disorganized if it had to endure persons who displayed such uncomfortable and alarming symptoms as acting frankly, doing justly, or seeking high ideals in common things. In face of this condition, Dr. McKown ought not to be surprised that the schools have sought to get by with lip service to character education, hoping that some benign result will follow if they only work their magic hard enough and seek esoteric and not too uncomfortably practical assistance.

It is well to have the author's carefully documented treatment of the "direct" versus the "indirect" method of applying character instruction, although one could wish that a man who knows so much of his subject would sometimes forget his impartiality long enough to argue vigorously for one or the other approach, since there appears to be enough documentation at hand to discredit pretty thoroughly what McKown describes as the "direct" approach, with its dependence upon non-existent "traits" and impossible preachment.

In the discussions of the character-education opportunities of the curriculum classroom, of extra-curricular activities, and of the home room, the reviewer sensed a faint nostalgia as he read, until he realized that he was rereading the familiar educational "clichés" which for the past twenty or thirty years have served to keep teachers from realizing that their first duty is to the personality of the child to be educated. While there is nothing particularly new or striking in the approach—even "progressive education" being discussed in roundly orthodox terms—the profession should thank the author for his straightforward and convincing style, and his brave assumption that at least some schools, even though a minority, do interpret their office as one of character-building. It is perhaps inevitable that in so comprehensive a work no space should be given to specific schoolroom situations or examples to illustrate how the excellent suggestions are to be practically carried out. The teacher, administrator, or parent to whom the book is directed will seek almost in vain for statements as to how to go about putting into effect the many plans suggested. It is fortunate, in view of this lack, that the entire volume is extremely well documented by bibliographical references.

The chief value of the book as a whole lies in its real usefulness

as a point of departure in thinking and experimentation. The well-stated criterion lists, usually in terms of outcomes sought, serve a fruitful purpose in the appraisal of home-room programs, validity of motives, and the behavior of teachers in character situations in school. It is perhaps trite to say that character cannot be taught, but can only be "caught" through insights developed out of maturation under benign influence.

The newer Gestalt psychology offers so much in the way of possible techniques that the reviewer regrets that the more conservative Thorndike and Charters should be so frequently cited as final authorities. Perhaps Dr. McKown will offer another volume, written with the same lucidity of phrase and the same downright honesty, in which he will call attention to the important researches recently carried on in the realm of the non-intellectual or affective factors in human education. Mental hygiene and good student personnel administration have so much to offer that is is to be regretted that Dr. McKown practically ignores this approach and still depends chiefly upon the older verbalization. If our author can be persuaded to cover this new field in the thoroughgoing reportorial manner typical of *Character Education,* we may yet be enriched by his efforts. Certainly the material will have the virtue of being new.

M. Ernest Townsend.

New Jersey State Normal School, Newark.

Woman's Mysteries, Ancient and Modern. By M. Esther Harding, M.D. New York: Longmans, Green, and Company, 1935. 342 p.

In this volume one of the foremost disciples of Jung presents a wealth of material, largely drawn from anthropological sources, regarding the symbolism of the moon. She introduces her subject with a chapter entitled *Myth and the Modern Mind.* Like Jung, she finds that the myths and rituals of ancient religions represent "the naïve projection of psychological realities" which have significance in modern as in ancient times. Particularly do they represent "the phantasy of the group . . . the unconscious processes of whole tribes or races . . . the intuitive insight of the race." She contrasts them with conventions and customs, the product of the conscious experience of real life.

The nine other chapters in Part I are concerned with the moon in myth and religion. Part II consists of five chapters on the moon as a symbol. "The symbol which above all others has stood throughout the ages for woman . . . is the moon." "To primitive man and to the poet and dreamer of to-day, the Sun is masculine and the Moon feminine . . . the Greater Light which rules the day of reason

and intellect and the Lesser Light which rules the night of instinct and the shadowy perceptions of the intuitive world."

As in her previous volume, *The Way of All Women,* Dr. Harding maintains that the feminine principle is that part of human nature which dictates the laws of relatedness, and that the feminine realm is especially that of human relationships. Like many others, she traces many of our modern ills to faulty human relationships, due to faulty individual development of the inner life of personality, especially of the feminine principle. In such unsatisfactory conditions as now prevail throughout the world, the ancients would have said that "the moon goddess, goddess of love and fertility, was absent from the world." Dr. Harding suggests that the way out of our modern impasse may lie through an effort toward "bringing the goddess back in the individual life through the psychological experiences which are the modern equivalent of the initiations of the moon goddess."

The value to the psychologist of familiarity with the myths and symbols of the moon is that often "symbols which arise in dreams and phantasies are strikingly similar to those of the old mystery religions, and the outcome in psychological development for the individual corresponds to the change which the initiation was said to produce." The author gives credit to Jung for making it possible to understand the constructive meaning of the products of the unconscious. "If these same symbols and rituals were interpreted reductively, as for instance by the Freudian method . . . the whole meaning of the initiation would have escaped observation."

Dr. Harding calls attention to the fact that the scientific attitude is changing. Whereas the search for truth has been entirely in the objective world, and the scientist has "paid attention to the inner psychical realm only that he might be sure to exclude it from his observations," now the definition of truth has been extended, so as to include the subjective, the non-material. Many people will agree with the author on that point, and will welcome her sincere and profound research for truth regarding human nature and human relationships.

FLORENCE MEREDITH.

Boston, Massachusetts.

NOTES AND COMMENTS

Compiled by
PAUL O. KOMORA
The National Committee for Mental Hygiene

NATIONAL SURVEY OF MENTAL HOSPITALS

A new effort to improve conditions in public hospitals for the mentally sick in the United States is in the making. After two decades of striking progress in the care and treatment of the insane and the feebleminded, we are again faced with grave questions of standards, quality of service, therapeutic resources, medical and nursing requirements, administrative efficiency, and other acute hospital problems. The bad economic situation of the past few years and the resultant curtailment of hospital budgets; the let-up in new construction and the consequent shortage of hospital beds, with many of the mentally ill relegated to jails and other unsuitable places of confinement in various parts of the country; the recurrence of political interference in institutional affairs; the steady increase in the numbers of those requiring hospital care; and other regressive factors bring the hospital issue once more to the fore and claim our attention again as it did a quarter-century ago when the mental-hygiene movement was founded.

Joining forces with the American Psychiatric Association, the American Medical Association, the American Neurological Association, the American Board of Psychiatry and Neurology, and the United States Public Health Service, we are returning to the attack in an attempt to conserve past gains and to press on toward further achievement. Thanks to the renewed support of the Rockefeller Foundation, whose benefactions were so large a factor in our work for hospital betterment in earlier years, we are in a position to take definite steps toward the effectuation of a working plan. We are also indebted to the United States Public Health Service and the American Psychiatric Association for supplementary grants of money and personnel.

Under this plan there has been set up the Mental Hospital Survey Committee, composed of nationally known leaders in psychiatry and neurology, representing the various organizations, who will guide and coördinate the effort. Dr. Walter L. Treadway, Assistant Surgeon General, in charge of the Mental Hygiene Division of the Public

Health Service, is chairman of the committee whose members are as follows:

Dr. S. Spafford Ackerly, Associate Professor of Psychiatry, University of Louisville, School of Medicine, Louisville, Ky.; Dr. Louis Casamajor, Neurological Institute, New York City; Dr. Ross McC. Chapman, Superintendent, Sheppard and Enoch Pratt Hospital, Towson, Md.; Dr. Franklin G. Ebaugh, Director, Psychopathic Hospital, University of Colorado, Denver, Col.; Dr. J. Allen Jackson, Superintendent, Danville State Hospital, Danville, Penn.; Dr. Arthur P. Noyes, Superintendent, Morristown State Hospital, Morristown, Penn.; Dr. Winfred Overholser, Commissioner, Department of Mental Diseases, Boston, Mass.; Dr. Frederick W. Parsons, Commissioner, Department of Mental Hygiene, Albany, New York; Dr. Arthur H. Ruggles, Superintendent, Butler Hospital, Providence, Rhode Island; Dr. William L. Russell, General Psychiatric Director, Society of The New York Hospital; Dr. H. Douglas Singer, Professor of Psychiatry, College of Medicine, University of Illinois.

This committee met recently to map a tentative program of study, and appointed Dr. Samuel W. Hamilton executive director of the project, which will be centralized at the offices of The National Committe for Mental Hygiene, 50 West 50th Street, New York City. Dr. Hamilton has had a wide experience as clinician and administrator, having served in several public and private hospitals. He was formerly associated with the National Committee in the conduct of state and local mental-hygiene surveys. Assisting him are Dr. Grover A. Kempf, Senior Surgeon, United States Public Health Service, who will serve as associate director of the project, and Joseph Zubin, Ph.D., social economist and statistician. Both Dr. Kempf and Dr. Zubin have been temporarily assigned to the committee for this purpose. Dr. Kempf has been an officer of the Public Health Service for twenty-four years, specializing in clinical and administrative psychiatry. He has made a number of mental-hygiene studies and recently completed a mental-health survey of public institutions in the State of Washington. Dr. Zubin's training and experience have been in the field of psychology and measurement. Before entering the Public Health Service he served as clinical psychologist at the New York State Psychiatric Institute and Hospital and as research assistant at Teachers College, Columbia University, and also taught educational psychology at the College of the City of New York.

Operations will begin this fall with a preliminary "orientation" survey leading to the formulation of a comprehensive, nation-wide program of activity. Steps will be taken to deal with such issues as overcrowding, housing needs, the planning of new construction,

staff requirements, therapeutic facilities, the segregation and classification of patients, training programs, out-patient services, administrative and fiscal problems, boarding-out schemes, community relationships, legislation, etc. Through general and special studies, experimental demonstrations, and other means, efforts will be made to assist state administrative and legislative bodies to raise the level of hospital work throughout the country. The question of standards will receive special study looking toward the eventual adoption of feasible hospital rating schemes to serve as a stimulus to the betterment of treatment facilities and the attainment of a higher grade of professional service. On all these matters the Mental Hospital Survey Committee will serve as a consultation bureau and clearing house of information for the benefit of state authorities responsible for the institutional care of the mentally ill. The project is financed for a three-year period, but we anticipate that it will occupy a central place in our activities for some time to come. For the development of adequate hospital and clinic facilities for the mentally ill is a fundamental condition of mental-health progress in its larger aspects and cannot lag behind other elements of the mental-hygiene program if we are to realize our ultimate aims.

State Hospitals and Research

Supplementing the program of the Mental Hospital Survey Committee is another project which The National Committee for Mental Hygiene is undertaking, under a special grant from the John and Mary R. Markle Foundation. Next to the training of psychiatric personnel, research into the causes of mental disease is the most important requirement for continued progress in the treatment and cure of the mentally ill. In spite of its importance, however, research in psychiatry has not been as well organized and financed as in other departments of medicine. We are spending more than $200,000,000 of public funds a year for the hospitalization and housing of mental patients, but less than $1,000,000 per annum for scientific studies. Such a governmental policy is inadequate and shortsighted. To stimulate publicly supported research in this wide field, we propose to survey existing arrangements and possibilities in this connection in state hospitals and clinics, to seek out the men and the opportunities available for scientific investigation in the various states, and to encourage measures for the development of sound activities along these lines. We are conducting an inquiry into the general situation at this time among strategic centers in this country and Canada as a preliminary to the formation of a practical plan of endeavor.

Research in Dementia Praecox

Significant progress in the work of the forty or more investigators engaged in the fourteen research projects in dementia praecox financed by the Scottish Rite Masons, Northern Jurisdiction, is reported by Dr. Nolan D. C. Lewis, coördinator of the program. While any announcement of findings would be premature at this time, Dr. Lewis regards them as highly promising and looks for achievements "that may well be epoch-making in the light of future developments."

An important by-product of this undertaking, in the meantime, growing out of his national survey of the field, is his compilation of various data on the past attainments, present trends, and future possibilities in the investigation of this problem. This is being published by The National Committee for Mental Hygiene in book form, under the title, *Research in Dementia Praecox,* and will be available for distribution on and after October 15. The publication announcement describes the work as presenting "a comprehensive picture of what is being done in the whole field of dementia-praecox research from every scientific angle," and as being, in a sense, "the foundation upon which the further development and future planning of investigation in this field will largely be based."

Dr. Lewis' book is highly commended to all who are interested in advancing scientific knowledge in regard to this obscure medical problem, and no psychiatrist contemplating original work on this or any other phase of psychiatric research will want to be without it. It will undoubtedly serve as a further stimulus to research effort and achievement in this promising field. To make it as widely available as possible the book will be sold at the low price of $1.50. Orders should be addressed to The National Committee for Mental Hygiene, 50 West 50th Street, New York City.

Problem Children in New York City's Schools

A widely extended program of measures dealing with problem children in the public schools of New York City was recommended by a special committee on delinquency and maladjustment in an interim report made to the board of education this summer. During the past year this committee held thirty-four meetings which were attended by members of the board of education and the board of superintendents and by representatives of the Welfare Council of New York City, institutions for delinquents, and various departments of the city government. A final report dealing with the committee's findings and recommendations as to policy and practice is to be made in the fall.

The proposed extension of services, embracing fifteen items, calls

for an addition of $1,600,000 to the regular school budget for 1937. Six of these items, estimated to cost $287,000, involve such specific mental-hygiene measures as the establishment of three new child-guidance clinics (in addition to the three already authorized by the board of education and due to open this fall); the appointment of twenty-five home and school visitors; the creation of a new position of chief investigator and social case-worker; provisions for a placement bureau for problem children and for thirty additional special classes for the mentally retarded; and a special appropriation for services to problem boys by child-caring organizations or in foster homes. Urging upon the board the adoption of all of these proposals as "minimal requirements," the committee concluded its report with the following statement:

> "Your committee is well aware that the extensions of service which it has proposed involve a large expenditure. It could not feel that it had done its duty, however, if it were not to point out the direction in which it believes the school system must develop if it is to deal adequately with the problems of maladjustment and delinquency, and if it is to tell the truth to the community which supports the schools.
>
> "We believe that curtailed budgets are not necessarily economical, that the slightly maladjusted child may develop into the problem child, that the problem child not only reduces the efficacy of classroom work, but if not properly handled, may, in many instances, develop into the delinquent, the criminal, and the ne'er-do-well."

As Educators See It

The proposal to enlarge child-guidance services in the New York City schools is strongly supported in a series of declarations appearing in the thirty-seventh annual report of the superintendent of schools for 1935. His propositions are based on a report of the activities of the Bureau of Child Guidance and apparently reflect unanimous agreement among school principals as to the urgency of the need for such services. They constitute such an excellent "platform" of mental-health principles in relation to school procedures and sound educational practice that we take the liberty of quoting them in full:

> "That sufficient time be given to teachers to study the individual personality of each child in her class, so that she may apply her deeper knowledge of child nature and her artistic skill in developing the good qualities of each child and in raising the child's potentialities to higher and more wholesome levels of growth and development.
>
> "That definite attempts be made to establish everywhere wholesome, stimulating, constructive, spiritual tone and atmosphere. We should emphasize at all times the importance and the value of developing and maintaining those warm, friendly, coöperative, understanding, sympathetic, patient, loving, and constructively helpful teacher-child relation-

ships which, all leading educators know, produce the best and most abiding results academically, socially, morally, and spiritually.

"That every teacher become more and more 'child conscious' rather than 'curriculum conscious.' This means a shifting of emphasis from subject matter to child personality, but it does not mean neglecting the transmittal of the great body of useful knowledge and valuable skills which are the cultural and spiritual inheritances of the ages. More attention to the child's fundamental and maturing needs for security, for growth and development will produce the best educational results.

"That teachers take every possible opportunity to achieve healthy physical, mental, moral, and spiritual growth and development so that each teacher may be able to share these valuable qualities of her own physical, emotional, volitional, moral, and spiritual maturity and personality with the children whom she endeavors to influence for good.

"That at least one well-trained coaching teacher to do intensive remedial work be appointed and assigned to each unit of the Bureau of Child Guidance.

"That more adjustment classes be organized in our junior high schools and in our elementary schools to meet the special needs of children who present problems of school maladjustment.

"That enriched educational and social programs be adopted to meet the needs of children with superior intelligence.

"That more hospital facilities for the study and treatment of children presenting early psychotic or severe neurotic manifestations be organized in the city. Such children frequently require hospitalization for continuous observation and intensive treatment.

"That free laboratory facilities be provided in our public hospitals for X-rays, basal metabolism, blood chemistry, sugar tolerance, and other biochemical tests. Such coöperative assistance is essential for the proper diagnosis and treatment of certain children referred to our Bureau.

"That the quantity and variety of educational material to be taught in any school grade be constantly and carefully reëxamined and weighed to determine whether a child of average intelligence in that grade can reasonably be expected to learn, to absorb, to apply, and to master the total knowledge which the teacher is asked to present within a school term.

"That more consideration be given to the techniques, economy, and hygiene of learning so that children may, without undue emotional strain or fatigue, progress step by step toward desirable goals of achievement.

"That more and more meaningful experiences be provided within the school so that each child may become more interested, better motivated, and wholesomely stimulated to exert his best efforts in acquiring and applying useful knowledge, developing desirable skills, forming right individual and social habits and attitudes, and becoming a well-balanced and well-integrated personality.

"That professional assistance be given to all teachers to enable them to learn more and more about the total child in his past and present environment, so that problems presented by each child may become better understood and that constructive coöperative guidance may be given to each child according to his real needs and capacities.

"That the recommendations submitted in previous reports of the Bureau of Child Guidance receive careful consideration.

"That the unanimous recommendations made by school principals and by all leading social agencies in our city for the extension of the services of the Bureau of Child Guidance to various school districts in our city receive favorable consideration."

National Council of Parent Education

The fifth biennial conference of the National Council of Parent Education will be held at the Edgewater Beach Hotel, Chicago, November 11–14. Like previous biennial meetings of the Council, this conference will take the form of a congress of workers engaged in various types and levels of education for family life, marriage, and parenthood.

Such problems as education for family living and home-making in programs of general education on the secondary level; the conduct of marriage and family counseling in relation to teaching, medicine, social work; parent education in adult-education programs; preparation of readable and reliable subject matter for various groups and age levels, and the like, will be discussed in round-table, panel, and free-discussion sessions. The relation of education for family living to contemporary trends in family life, to current developments in education, and to recent economic and social changes, will be the subjects of addresses at two general sessions.

For those who wish more specific help in their work, there will be a series of study courses, of four or five sessions each, conducted by recognized leaders, on such topics as the techniques of adult-discussion-group leadership, the mental hygiene of teaching college courses on marriage and the family, and the training and supervision of lay leaders.

Those desiring to attend, or wishing further information, should communicate with the Director of the National Council of Parent Education, 60 East 42nd Street, New York City.

Second National Conference on College Hygiene

Fresh viewpoints on the responsibilities of our higher institutions of learning for the protection of student health are promised in the preliminary announcement of the Second National Conference on College Hygiene to be held at the Wardman Park Hotel, Washington, D. C., December 28-31. The conference will be sponsored by the American Student Health Association, the Presidents' Committee of Fifty on College Hygiene, and the National Health Council, with the aid and coöperation of the College Physical Education Association, the American Association of School Physicians, and other

interested agencies. Instead of the conventional program with prepared addresses, there will be five sections comprising working committees which will consider such topics as health service, health teaching, organization, relationship of college hygiene to teacher training, and special problems. Mental-health interests will be represented by Dr. William A. White, Dr. Arthur H. Ruggles, Dr. Theophile Raphael, Dr. Clements C. Fry, Dr. Helen Langner, Dr. John M. Murray, and Dr. Bruce B. Robinson. Dr. Livingston Farrand is president of the conference and Dr. William F. Snow and Miss Louise Strachan are chairman and secretary, respectively, of the organizing committee. Further information may be obtained from the executive office of the committee, Room 828, 50 West 50th Street, New York City.

Tenth Iowa Child-Development Conference

"Education for Family Life" was the theme of the Tenth Iowa Conference on Child Development and Parent Education held under the auspices of the Iowa Child Welfare Research Station in Iowa City, June 16 to 18. Seventeen organizations and over a thousand delegates from 31 states and three foreign countries participated in the discussions, which ranged over a variety of topics, including training for marriage, home economics, leisure-time programs, elementary and nursery-school education, mental hygiene, and adult and child guidance.

Family misunderstandings and the influence of the home in combating excessive drinking, eroticism, and other symptoms of the "fast life" were discussed by Professor Floyd Allport, of Syracuse University, and Professor Hornell Hart, of Hartford Theological Seminary. "Delinquent boys, their natural urge for self-assertion blocked at other points, carry on exactly the same activities in plundering city areas as other little boys at home playing Robin Hood," Professor Allport declared. Suggesting methods by which the home might supply youth with wholesome "thrills" in place of the lures of speeding, drinking, and sex, Professor Hart observed that "fears and bogeys have not been eliminated from sex life"; that whereas attitudes and behavior in this sphere were formerly inspired by fear of punishment or venereal disease, they are to-day motivated by considerations of health and the dangers arising from unhealthful inhibition and restraint. "This is an age of experimentation," he said, "but youth must be taught that one cannot experiment with one's body and soul as one does with guinea pigs." Recognizing this, scientific pre-marital training for normal young men and women is being offered increasingly by churches and schools, he said, describing

the "marriage course" he initiated two years ago at the University of Iowa.

The modern adult in dealing with children must be less a fault-finder and more a "power-finder" was the injunction to parents voiced by Professor Hughes Mearns, of New York University, in his comments on the newer spirit in child training. Disobedience is still important as a factor in children's behavior, but the child who disobeys is driven by a stronger urge than adult control. "If we can discover that compelling force in his life, we can do all our instructing through that dominant interest." As Professor William C. Reavis of the University of Chicago put it in discussing this point, "schools are no longer bitter medicine," and children must be helped to develop worth-while occupations through which they can express a major interest.

Dr. Robert G. Foster, of the Merrill-Palmer School in Detroit, asserted that it is no longer a disgrace to admit that one's child is a problem, for the parent without a problem is "either subnormal or supernormal." This was proved, Dr. Foster said, by a survey based on an inquiry among a large group of college-trained women, selected at random, which revealed that "nearly all of these perfectly normal women had a serious problem of some kind."

Dr. Bruce B. Robinson, Director of the Newark (N. J.) Child Guidance Clinic, declared that a satisfactory visual-education program for the child with an I.Q. of 70 to 90 was one of the most pressing educational problems to-day. "The elementary school is on its way toward solving the problem with handicrafts, exhibits, trips to museums, etc.," he said, "but the high-school teacher has, in general, taken a defeatist attitude toward the adolescent of low intelligence who is increasingly being forced to stay in school until he is sixteen or more." These older pupils, most of whom will probably be required, in the future, to remain in school until they are eighteen, are definitely the problem of the high-school teacher, he continued. "They will never be able to read for pleasure, will never feel it worth while," in spite of the fact that many families demand cultural courses even for "slow" students. Nor are vocational courses the solution, Dr. Robinson said. "We sacrifice these children to books, giving them a 'compulsory education' that is only a 'compulsory attendance.' Why develop a hopeless attitude in the child who will later be a perfectly good voter and office-holder? Omit what he does not like. If you cannot interest a child in a subject, drop it. Put others, who feel as he does, in the same class with him, and build their self-respect with courses they think worth while. More movies and exhibits that teach citizenship, health, sociology, and geography should be the solution for this type of pupil."

State Society News

Indiana

The Indiana Society of Mental Hygiene held its annual meeting in Indianapolis last May. The program included general sessions with formal addresses and informal discussion groups. Out-of-state speakers were Dr. Andrew W. Brown, Chief Psychologist of the Illinois Institute for Juvenile Research; Miss Helen L. Myrick, General Director of the Illinois Society for Mental Hygiene; Dr. Karl Camp, Professor of Neurology, University of Michigan; and Miss Florence Day, Regional Secretary of the Family Welfare Association of America. President Donald DuShane, Superintendent of Schools, Columbus, presided.

At the opening session, at which Dr. W. C. Van Nuys, Superintendent of the Village for Epileptics, Newcastle, presided, Miss Myrick spoke of the function of a mental-hygiene society and the various ways in which it may foster positive mental health in the community. As a privately supported body, it can work as a free lance in the education of public opinion and the provision of needed legislation; it can criticize publicly or privately in a constructive way, where conditions or methods need to be changed; and it can coöperate with governmental agencies in maintaining improvements that have been achieved. The mental-hygiene society, Miss Myrick said, must carry its message to the people in the highways and byways to help every one of us live our lives more effectively.

Dr. Brown followed with a paper in which he pointed out that treatment consists in changing behavior that is objectionable, human behavior being but the expression of mental habits, good or bad. To break down undesirable habits and to substitute socially accepted behavior, it is necessary to understand the fundamental laws of learning, and then, after reëducation, to modify the environment that has brought about the maladjustment.

Speaking on "Some Significant Aspects of Adolescence," Dr. Conklin, Head of the Department of Psychology of Indiana University, discussed as having a bearing on the study of adolescence (1) the socialization of attitudes which must come at this period; (2) understanding of the different growth periods that precede adolescence; (3) the principle of unevenness of development, which means that the social, educational, economic, and mental development may not proceed at the same rate; and (4) recognition of the development of ideals. He brought out particularly what happens to the child who is given too much protection or an excessive amount of affection in the home and what happens because of the lack of such affection and protection.

After Dr. Conklin's address, the audience divided into four discussion groups. Dr. Conklin continued his discussion on the subject of adolescence. Miss Myrick led a small, but enthusiastic group of outstanding club women interested in learning how their various organizations may participate in the mental-hygiene movement and where they may turn for study material. Miss Day presented before a group of family-welfare case-workers a short interview with a client, whose problem, as she saw it—namely, the need for financial assistance—was not the need about which the worker should have been most concerned. Uncovering of the client's attitude was shown to be necessary in solving her emotional difficulties and making it possible for her to carry on.

A fourth group, presided over by W. A. Hacker, of the state board of public welfare, discussed "A State Mental-Hygiene Program." Dr. Camp described the work of the State Psychopathic Hospital and the community clinics in operation in Michigan. "A mental-hygiene program," said Dr. Camp, "can succeed only by enlisting the active and sympathetic support of the family doctor. He is the foundation stone of a good plan." Speaking again at a luncheon meeting, Dr. Camp stressed the point that mental health is always a medical problem, adding that the magnitude of the problem and the relative indifference to it on the part of the public is astonishing. He described various types of mental disorder and urged more research, increased interest on the part of the medical profession, and, on the part of the public, a realization of the importance of early signs of maladjustments.

The final session of the conference was devoted to a discussion of the relation of mental hygiene to delinquency. Dr. Edwin Sutherland, President of the Indiana Institute of Criminal Law and Criminology, presided. The speakers were Dr. Max A. Bahr, Elmer Ward Cole, Dr. R. Clyde White, and Dr. Harriet E. O'Shea. The closing address of the conference by Dr. O'Shea, on "Mental Mechanisms to Be Considered in a Preventive Program," urged that we endeavor to recognize attitudes and habits which may become serious difficulties, ultimately necessitating hospital care, and provide in their place experiences that will turn the drift of the person's habit formation in another direction.

New York

The establishment of mental-hygiene courses in training schools for nurses in general hospitals, the beginnings of a practical mental-hygiene program for public-health nurses, publication of a study of unemployment-relief methods for public and private welfare officials, social workers, and relief agencies, and other achievements and activi-

ties of the New York Committee on Mental Hygiene are reviewed in the annual report of the State Charities Aid Association for 1935. About 18,000 pamphlets were distributed by the committee during the year, in the course of its educational work which includes the widely used services of a speakers' bureau, the work of a special committee on mental-hygiene legislation, an information service on personal problems, assistance to local mental-hygiene and affiliated groups, field work, and other projects looking to the development and improvement of mental-health resources throughout the state. A particularly helpful publication is the popular pamphlet, *State Institutions: How To Use Them Wisely,* which has just been revised and reprinted for general public instruction.

The outstanding activity of the New York City Committee on Mental Hygiene during the past year has been the work of its special committee for the study of standards of training of professional personnel in psychiatric clinics in Greater New York. A new planning committee has also been organized, together with a number of subcommittees to deal specifically with such subjects as child guidance, mental deficiency, the mentally sick, and neurological cases. Three series of case discussions were held under the joint auspices of the New York City Committee and the Bureau of Child Guidance of the public schools, and a special seminar course carrying college credit was established in coöperation with the College of the City of New York. A selected list of lecture courses in mental hygiene given in various educational centers in the city was also issued. Approximately 13,000 mental-hygiene pamphlets were distributed to public-school teachers alone. The committee is also coöperating with the Welfare Council in plans for the improvement of information services and better interpretation of social work throughout the city.

South Australian Council for Mental Hygiene

Glowing reports of Australia's climb out of the world depression are appearing in the news. No less encouraging is the word that comes to us from Adelaide of the formation in that city of a Council for Mental Hygiene for South Australia. Mental-hygiene societies are now in operation in three of Australia's seven states, Victoria and New South Wales having previously organized similar councils. Thus another step has been taken, writes our informant, Miss Stella E. Pines, Secretary of the Adelaide group, toward the eventual establishment of a National Council for Mental Hygiene. Last year, Miss Pines formed "The Auxiliary for Occupational Therapy in Mental Hospitals of South Australia" as a stimulus to the further development of organized mental-hygiene work in that state. Contrary to the experience in other countries, most of which have set up national

societies at first, the procedure in Australia seems to be to build up a system of local organizations as a basis for later national effort. Wisely, the leaders of the movement in Adelaide are focusing their attention on the provision of more adequate institutional facilities for their mentally ill as a preliminary to broader mental-health objectives. At the same time the composition of the committee which organized the new council gives promise of a widely representative support of the movement as it relates to more inclusive goals.

Following is a roster of the committee: Dr. H. Birch, Medical Superintendent, Parkside Mental Hospital; Dr. C. C. de Crespigny, Dean of Medicine, University of Adelaide; Dr. Constance Davey, Psychologist to Department of Education; Mr. J. T. Massey, General Secretary, Y.M.C.A.; Dr. E. Allen, Psychologist to Child Guidance Clinic, Children's Hospital; Principal Lade, St. Peter's College; Dr. Penny, Assistant Director, Teachers College; Justice Richards, Supreme Court; Mr. R. S. Coombes, Magistrate, Juvenile Court, Adelaide; Mr. Lushey, Department of Education; Mr. D. Clarkson, representing industry; Dr. L. W. Jeffries, Inspector General of Hospitals, S. A.; Dr. C. Fenner, Acting Director, Department of Education; Miss P. Watson, Principal, Teachers College; Principal and Mrs. Kiek, Parkin College; Professor Hicks, Professor Physiology, University of Adelaide; and Mr. E. Bagot, representing Boys Employment Council. Dr. H. K. Fry is chairman of the committee.

The Rockefeller Foundation

Psychiatric teaching and research came in for a major share of the benefactions of The Rockefeller Foundation during 1935, according to its last annual report. In that year the Foundation spent $12,725,439 for a variety of activities in the broad fields of public health, the natural and social sciences, and the humanities. For work in the medical sciences, it appropriated $2,733,050, over half of which went to projects for the advancement of psychiatry and mental hygiene. Work in mental health was furthered through the medical sciences, particularly by "aid to the teaching of psychiatry and to the study of the complex phenomena of mental disease and maladjustment"; and through the natural sciences projects were assisted which "focused the techniques of the exact sciences upon research important for understanding human development, and for furnishing the basis of much of the research in psychiatry." Grants for undertakings in psychiatry, neurology, and related fields were made to sixteen American and four foreign scientific centers, as follows:

Institute for Psychoanalysis, Chicago; Johns Hopkins University School of Medicine; Institute of the Pennsylvania Hospital; Harvard Medical School; Massachusetts General Hospital; University of

Michigan Medical School; University of Colorado School of Medicine; University of Chicago School of Medicine; Columbia University College of Physicians and Surgeons; Worcester (Mass.) State Hospital; Cornell University Medical College; Northwestern University Medical School; New York University College of Medicine; Massachusetts Department of Mental Diseases; North Carolina Commission for the Study of the Care of the Insane and Mental Defectives; The National Committee for Mental Hygiene; Maudsley Hospital, London; University of London; University of Amsterdam; and the Institute of Educational Sciences, Geneva.

1934 Institutional Census of Canada

The Dominion Bureau of Statistics reports a total of 58 institutions for the insane, feebleminded, and epileptic in operation in Canada in 1934, and a total of 39,106 patients under care and treatment during that year in 56 of these institutions, for which data were available, according to its third annual enumeration just published. This represents an incidence of institutional cases of 335 per 100,000 of the general population, compared with a rate of 305 per 100,000 in 1931. The rate of first admissions of psychotic patients, which is an indication of the present course of mental disorder in the Dominion, was 47 per 100,000 of population. For all patients, with and without psychoses, the rate was 73 per 100,000. The proportion of men to women among the resident patient population of institutions for the insane was 123:100; but among the patients admitted during the year the ratio was 140:100. About 11.5 per cent of the patients were discharged during the year, 3.5 per cent as cured and 5.1 per cent as improved. The per capita cost of care and treatment was 97 cents—80 cents for maintenance and 17 cents for other expenses. About 13 per cent of the hospital expenditures were defrayed by income from paying patients. There were 156 patients per physician, and 40.5 patients per graduate nurse; and the ratio of patients to all employees was 5.8 to 1.

CURRENT BIBLIOGRAPHY *

Compiled by

FREDERICK W. BROWN

Adamson, Elizabeth I., M.D. A community program for prevention of mental disease. American journal of public health, 26:480–88, May 1936.

A Father. Mistakes I've made with my boy. Parents' magazine, 11:20, 50–51, July 1936.

Aikins, H. Austin. College standards and human values. Mental hygiene, 20:366–83, July 1936.

Anderson, C. L. Epilepsy in the state of Michigan. Mental hygiene, 20: 441–62, July 1936.

Anderson, Forrest N., M.D. A mental-hygiene survey of problem Indian children in Oklahoma. Mental hygiene, 20:472–76, July 1936.

Baber, Ray Erwin. Some mate selection standards of college students and their parents. Journal of social hygiene, 22:115–25, March 1936.

Bagchi, B. K. Mental hygiene and the Hindu doctrine of relaxation. Mental hygiene, 20:424–40, July 1936.

Barrett, Rev. John W. What is an eleemosynary charter? A consideration of its privileges, its responsibilities, and its abuses. Modern hospital, 47:57–59, August 1936.

Beck, L. F. Hypnotic identification of an amnesia victim. British journal of medical psychology, 16:36–42, May 18, 1936.

Berk, Arthur, M.D., Lane, Lenore, and Tandy, Myrtelle C. A follow-up study of thirty habit clinic children who manifested delinquency problems before age of ten years. Bulletin of the Massachusetts department of mental diseases, 19:37–57, April 1935.

Blanchard, Phyllis. Reading disabilities in relation to difficulties of personality and emotional development. Mental hygiene, 20:384–413, July 1936.

Boykin, Eleanor. Should mothers be matchmakers? Parents' magazine 11:20–21, 69, August 1936.

Bradbury, Dorothy E. The case for nursery schools. Childhood education, 12:406–08, 29, June 1936.

Canavan, Myrtelle M., M.D., and Clark, Rosamond. Second report on the mental health of dementia praecox stock. Bulletin of the Massachusetts department of mental diseases, 19:17–23, April 1935.

Canavan, Myrtelle M., M.D., and Clark, Rosamond. The mental health of children of dementia-praecox stock: second report. Mental hygiene, 20: 463–71, July 1936.

Carpenter, Louise. Keeping "awake in your mind." Progressive education, 13:254–59, April 1936.

Casparis, Horton R., M.D. Some of the preventive aspects of the mental health problem. Journal of the American medical association, 106: 2207–09, June 27, 1936.

Cattell, Raymond B. Temperament tests in clinical practice. British journal of medical psychology, 16: 43–61, May 18, 1936.

Cheney, Clarence O., M.D. Trends in psychiatric research. Psychiatric quarterly, 10:224–31, April 1936.

Condell, Lucy. The library as a road to reëducation in responsibility for neuropsychiatric patients. Medical bulletin of the veterans' administration, 13:77–84, July 1936.

Cowell, Joseph Goss. Report on recreative therapy. Bulletin of the Massachusetts department of mental diseases, 19:57–65, April 1935.

Crowley, Ralph. Coöperation between home and school. New era in home and school, 17:207–10, July–August 1936.

Davies, Stanley P. The rôle of social case-work in marriage and family consultation services. Family, 17: 145–51, July 1936.

Deutsch, Albert. The cult of curability, its rise and decline. A page from psychiatric history. American journal of psychiatry, 92:1261–80, May 1936.

* This bibliography is uncritical and does not include articles of a technical or clinical nature.

Doll, Edgar A. The scientific point of view toward the prevention of crime. Journal of criminal law and criminology, 27:203–06, July–August 1936.

Dunsdon, M. I. Backwardness. New era in home and school, 17:125–27, May 1936.

English, O. Spurgeon. On the necessity of applying psychotherapy exclusively. Medical record, 143:384–86, May 6, 1936.

Erickson, Milton B. Opportunities for psychological research in mental hospitals. Medical record, 143:389–92, May 6, 1936.

Farnell, Frederick J. Refining the personality. Medical record, 144:55–58, July 15, 1936.

Fechheimer, Richard. The "why" of children's lies. Hygeia, 14:505–08, June 1936.

Feder, Leah. Who is to do the job? Family, 17:163–69, July 1936.

Field, H. E. The problem of juvenile delinquency. New era in home and school, 17:131–35, May 1936.

Foster, Robert G. Is family counseling a profession? Journal of social hygiene, 22:125–29, March 1936.

Frances, Mary. Why boys leave home—the problem of the transient boy. National parent-teacher magazine, 30:8–9, 26, 29–31, August 1936.

Franklin, Zilpha Carruthers. When they ask about babies—good and bad answers to the questions that every child is sure to ask. Parents' magazine, 11:25, 87, 91–92, June 1936.

Fries, Margaret E., M.D. The study of the emotional development of children. Medical woman's journal, 43:199–202, August 1936.

Garth, Thomas R., Elson, Thomas H., and Morton, Margaret M. The administration of non-language intelligence tests to Mexicans. Journal of abnormal and social psychology, 31:53–58, April–June 1936.

Gleich, Morris. The preschool child who misbehaves. Hygeia, 14:613–15, July 1936.

Gosline, A. J., M.D. Treatment of prepsychotic personalities of the schizoid and cycloid types. Psychiatric quarterly, 10:454–63, July 1936.

Green, James Sonnett, M.D. The stutter-type personality and stuttering. New York state journal of medicine, 36:757–65, May 15, 1936.

Groves, Ernest R. Education for marriage. Parents' magazine, 11:15, 56–58, July 1936.

Hallowell, A. Irving. Psychic stresses and culture patterns. American journal of psychiatry, 92:1291–1310, May 1936.

Hansl, Eva vB. Why children run away. Parents' magazine, 11:18–19, 73, July 1936.

Houston, W. R., M.D. Cardiac neuroses. Southern medical journal, 29:404–07, April 1936.

Huxley, Julian S. Eugenics and society. Eugenics review, 28:11–31, April 1936.

Ilma, Viola. What American youth is thinking. National parent-teacher magazine, 30:6, 39–41, July 1936.

Isaacs, Susan. Testing the development of young children. Mental welfare (London), 17:71–75, July 1936.

Jelliffe, Smith Ely, M.D. Mental attitudes vs. health. Hygeia, 14:710–12, August 1936.

Kelty, William. The road ahead for youth. National parent-teacher magazine, 30:7, 38–39, July 1936.

Kraines, S. H., M.D. Standards for private sanitariums for the care of patients with nervous or mental diseases. Illinois medical journal, 69:530–33, June 1936.

Kugelmass, I. Newton, M.D. Depression children. Archives of pediatrics, 53: 386–96, June 1936.

Lake, Michael, M.D. Selective tests used in industry to measure specific abilities and aptitudes. New York state journal of medicine, 36:1025–29, July 15, 1936.

Lewis, Nolan D. C., M.D. The pathology of mental disorders. New York state journal of medicine, 36:1101–08, August 1, 1936.

Lippman, H. S., M.D. When children are afraid. National parent-teacher magazine, 30:8–9, 41, July 1936.

MacCalman, D. R., M.D. Jealousy, shyness and fears. New era in home and school, 17:118–22, May 1936.

Malzberg, Benjamin. Marital status in relation to the prevalence of mental disease. Psychiatric quarterly, 10:225–61, April 1936.

Marcus, Grace F. Case-work interpretation: an area for professional exploration. Family, 17:169–74, July 1936.

Martens, Elsie H. Exceptional children and you. National parent-teacher magazine, 30:12–13, 32–33, June 1936.

Mason, Max. Science and the rational animal. Science, 84:71–76, July 24, 1936.

May, Mark A. Is there a science of human relations? Family, 17:139–44, July 1936.

McLaren, Chas. D., M.D. An approach to the interpretation and to the treatment of the psychoneuroses and the psychoses. The medical journal of Australia. Lecture I. May 16, 1936, 665–70; Lecture II. May 23, 1936, 698–707.

Milici, Pompeo, M.D. Simulated foolishness and mental puerilism in the psychoses. Psychiatric quarterly, 10:417–37, July 1936.

Miller, Emanuel. Organization of a child guidance clinic. New era in home and school, 17:137–48, May 1936.

Child guidance under an education authority, by C. L. C. Burns.

Guy's hospital child guidance clinic, by K. Duguid.

The northwestern child guidance clinic, by Elizabeth E. Irvine.

Child guidance in a catholic community, by Sister Maries Hilda.

Guidance through play.

Moore, Harry H. Gangsters, slums and demagogues in secondary education. Progressive education, 13: 275–81, April 1936.

Neumann, Henry. Marriage and morals. Journal of social hygiene, 22:102–14, March 1936.

Opler, M. E. Some points of comparison and contrast between the treatment of functional disorders by Apache shamans and modern psychiatric practice. American journal of psychiatry, 92:1371–87, May 1936.

Overholser, Winfred, M.D. The place of psychiatry in the criminal law. Psychiatric quarterly, 10:197–223, April 1936.

Papurt, Maxwell Jerome. A psychologist looks at prison case-work. Journal of criminal law and criminology, 27:68–74, May–June 1936.

Patry, Frederick L., M.D. Integrating mental hygiene: from the point of view of the public health officer and school physician. American journal of public health, 26:471–79, May 1936.

Payne, Sylvia M. Post-war activities and the advance of psychotherapy. British journal of medical psychology, 16:1–15, May 18, 1936.

Peck, Martin W., M.D. The story of psychotherapy. Mental hygiene, 20: 353–65, July 1936.

Pollock, Horatio M. The family-care system in Scotland. Mental hygiene, 20:414–23, July 1936.

Pollock, Horatio M., Malzberg, Benjamin, and Fuller, Raymond G. Hereditary and environmental factors in the causation of dementia praecox and manic-depressive psychoses. Psychiatric quarterly, 10:495–509, July 1936.

Prout, Thomas P., M.D. The place of the private psychiatric sanatorium. Medical record, 143:392–94, May 6, 1936.

Raphael, Theophile, M.D. Albert Moore Barrett. Mental hygiene, 20: 477–78, July 1936.

Schroder, Paul. Psychopathic personality and character abnormality. Bulletin of the Massachusetts department of mental diseases, 19:1–6, April 1935.

Scott, Elizabeth. And the deaf shall speak. Hygeia, 14:713–14, August 1936.

Searl, Nina. Freudian light on children's behavior. New era in home and school, 17:128–30, May 1936.

Seth, George. The treatment of disorders of speech. New era in home and school, 17:122–25, May 1936.

Shuey, Herbert. The relationship of body build to mental disease and behavior problems. Bulletin of state institutions (Iowa), 38:10–19, January 1936.

Slater, Eliot, M.B. The inheritance of manic-depressive insanity. Proceedings of the royal society of medicine (London), 29:981–90, June 1936.

Smith, May. "Nerves" as a handicap to efficiency. Mental welfare (London), 17:65–70, July 1936.

Spencer, Harvey, M.D. Adoption of children. Bulletin of the Massachusetts department of mental diseases, 19:14–17, April 1935.

Stanley, Josephine. Habit training for psychotic patients. Medical bulletin of the Veterans' administration, 13: 73–76, July 1936.

Steer, Max Davis, and Johnson, Wendell. An objective study of the relationship between psychological factors and the severity of stuttering. Journal of abnormal and social psychology, 31:36–46, April–June 1936.

The problem of juvenile delinquency. New era in home and school, 17: 155–69, June 1936.

In Brussels, by Aimée Racine.

In the U.S.S.R., by Noel Brinton.

In Vienna, by M. Michalski and R. Krottendorfer.

In Paris, by Olga Spitzer.

Thom, Douglas A., M.D., and Winslow, Dorothy C. A follow-up study of fifty problem children with poor prognosis and fifty problem children with good prognosis. Bulletin of the Massachusetts department of mental diseases, 19:24–37, April 1935.

Thom, Douglas A., M.D. Parent-child relationship. Bulletin of the Massachusetts department of mental diseases, 19:6–14, April 1935.

Thompson, Sylvia. Children are like that. Parents' magazine, 11:24–25, 72–73, July 1936.

Toffelmier, Gertrude, and Luomala, Katharine. Dreams and dream interpretation of the Diegueño Indians of southern California. Psychoanalytic quarterly, 5:195–225, April 1936.

Tomalin, B. Child guidance in relation to medical psychology. Mother and child (London), 7:133–36, July 1936.

Tousley, Clare M. Case-work principles in interpretation. Family, 17: 174–76, July 1936.

Tucker, Beverley R., M.D. Expert testimony and its relation to mental responsibility and neurological injury. Virginia medical monthly, 63: 267–71, August 1936.

Vold, George B. The training of the criminologist. Journal of criminal law and criminology, 27:180–89, July–August 1936.

Waite, Florence T. New emphasis in family social work. Family, 17: 156–63, July 1936.

Wall, James Hardin, M.D. A study of alcoholism in men. American journal of psychiatry, 92:1389–1401, May 1936.

Washburne, John N. The mental development of adolescents. Progressive education, 13:240–45, April 1936.

Weber, Hilda, M.D. An approach to the problem of fear in children. Journal of mental science (London), 82:136–47, March 1936.

Wender, Louis, M.D. The dynamics of group psychotherapy and its application. Journal of nervous and mental disease, 84:54–60, July 1936.

West, Robert. Is stuttering abnormal? Journal of abnormal and social psychology, 31:76–86, April–June 1936.

White, William A., M.D. Personality, psychogenesis, and psychoses. Journal of nervous and mental disease, 83:645–60, June 1936.

Wile, Ira S., M.D. Life and love. A symphony in C major and B minor. New York state journal of medicine, 36:1035–48, July 15, 1936.

Wile, Ira S., M.D. Physical and physiological growth as a factor in child adjustment. New York state journal of medicine, 36:809–13, May 15, 1936.

Zilboorg, Gregory, M.D. Suicide among civilized and primitive races. American journal of psychiatry, 92:1346–69, May 1936.

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